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The Massachusetts Medical Society

ANNUAL MEETING OF THE COUNCIL

THE annual meeting of the Council was held at Worcester in the Ballroom of the Hotel Bancroft, on Tuesday, June 5, 1934, at 12 o'clock, noon. The President, Dr. William H. Robey, Suffolk, was in the chair and the following 156 Councilors present:

BARNSTABLE
W. D. Kinney

BERKSHIRE
W. P. Kelly
H. J. Downey
W. T. Frawley

BRISTOL NORTH
W. H. Allen
A. R. Crandell
B. M. Latham

BRISTOL SOUTH
R. B. Butler
J. A. Barre
G. W. Blood
E. F. Cody
E. D. Gardner

ESSEX NORTH
E. S. Bagnall
R. V. Baketel
J. F. Burnham
T. R. Healy
E. P. Laskey
F. W. Snow
L. T. Stokes
W. D. Walker

ESSEX SOUTH
C. L. Hoitt
N. P. Breed
J. F. Donaldson
O. S. Pettingill

FRANKLIN
H. M. Kemp
H. G. Stetson
A. H. Wright

HAMPDEN
F. H. Allen
E. P. Bagg, Jr.
J. M. Birnie
W. A. R. Chapin
G. D. Henderson
M. W. Harrington
M. B. Hodskins
E. A. Knowlton
J. Z. Naurison
M. W. Pearson
A. G. Rice
G. L. Schadt
H. L. Smith
G. L. Steele

HAMPSHIRE
A. J. Bonneville
J. G. Hanson

MIDDLESEX EAST
J. H. Fay
J. H. Blaisdell
Richard Dutton
E. M. Halligan
K. L. Maclachan
R. R. Stratton
E. E. Tyzzer

MIDDLESEX NORTH
M. L. Alling
A. R. Gardner
T. A. Stamas

MIDDLESEX SOUTH
A. H. Blake
E. W. Barron
E. H. Bigelow
G. F. H. Bowers
W. H. Crosby
D. F. Cummings
D. C. Dow
A. W. Dudley
H. Q. Gallupe
W. G. Grandison
N. M. Hunter
C. M. Hutchinson
A. A. Levi
C. E. Mongan
Dwight O'Hara
C. T. Porter
S. H. Remick
F. G. Smith
H. P. Stevens
Fresenius Van Nüys

NORFOLK
Cadis Phipps
F. G. Balch
H. G. Batchelder
A. S. Begg
D. N. Blakely
W. L. Burrage
D. G. Eldridge
I. A. Finkelstein
J. B. Hall
L. F. Johnson
G. W. Kaan
W. A. Lane
J. S. H. Leard
Charles Malone

NORFOLK (Cont.)
F. P. McCarthy
L. T. McCready
Hyman Morrison
T. J. Murphy
Benjamin Parvey
Victor Safford
H. F. R. Watts

NORFOLK SOUTH
C. S. Adams
W. G. Curtis
G. V. Higgins
F. E. Jones
N. R. Pillsbury
C. A. Sullivan

PLYMOUTH
P. H. Leavitt
T. H. McCarthy
J. J. McNamara
G. A. Moore

SUFFOLK
J. W. Bartol
G. H. Bigelow
Horace Binney
C. S. Butler
R. C. Cochrane
F. J. Cotton
W. P. Cross
Lincoln Davis
Reginald Fitz
Channing Frothingham
H. W. Goodall
H. T. Hutchins
E. P. Joslin
R. I. Lee
G. B. Magrath
J. H. Means
T. J. O'Brien

SUFFOLK (Cont.)
W. S. Parker
G. P. Reynolds
W. H. Robey
Louisa Paine Tingley
H. P. Towle
Shields Warren

WORCESTER
J. C. Austin
W. P. Bowers
L. R. Bragg
F. H. Clapp
P. H. Cook
W. J. Delahanty
G. A. Dix
G. E. Emery
M. F. Fallon
Homer Gage
J. J. Goodwin
David Harrower
E. L. Hunt
E. R. Leib
A. W. Marsh
E. C. Miller
J. W. O'Connor
W. C. Seelye
E. H. Trowbridge
F. H. Washburn
R. P. Watkins
S. B. Woodward

WORCESTER NORTH
C. B. Gay
F. R. Dame
T. R. Donovan
A. F. Lowell
F. M. McMurray
H. R. Nye
W. F. Sawyer

The record of the last meeting was read in abstract by the Secretary, and as no omissions or corrections were noted it was accepted as read and as published in the "Proceedings" in the official organ of the Society. The President read obituaries of three Councilors who had died recently as follows:

Since the last meeting of the Council death has taken from us three of our members.

DR. THOMAS HENRY O'TOOLE died at his home in Norwood on April 4, 1934 at the age of sixty-two. He was born in Clinton, Massachusetts, but moved to Philadelphia, Pennsylvania, where he received his early education, later being graduated from Johns Hopkins University and Jefferson Medical College of Philadelphia in 1897. He settled in Norwood where he practiced for thirty-five years.

Dr. O'Toole joined the Massachusetts Medical Society in 1922 and was a member of the Council at

the time of his death. He was a Fellow of the American Medical Association.

He is survived by his widow, a daughter and a son, Dr. Thomas Henry O'Toole, who is a Fellow of the Massachusetts Medical Society.

DR. STEPHEN ANDREW MAHONEY, SR. died at his home in Holyoke on March 30, 1934, of a heart attack. He was born in North Brookfield in 1863. His premedical education was acquired at Holy Cross College where he was given the degree of Bachelor of Arts in 1885. His medical degree was conferred by the Harvard Medical School in 1889.

He began practice in Holyoke and in 1892 was appointed City Physician and a member of the Board of Health Survey, serving until 1894. After a few years of general practice he devoted his major interest to surgery and in later years restricted his work to this specialty. Dr. Mahoney was surgeon on the staffs of the Holyoke City and Providence Hospitals and was also Chief of Staff of the Memorial Clinic in Holyoke.

Dr. Mahoney joined the Massachusetts Medical Society in 1888, was a member of the Council for many years taking an active part in the debates at meetings. He was also a member of the New England Surgical Society and a Fellow of the American Medical Association.

He is survived by his widow, two sons, one daughter and a sister. One son, Dr. Stephen A. Mahoney, is a Fellow of the Massachusetts Medical Society.

DR. WILLIAM HOWARD ENSWORTH died at his home in East Boston May 3, 1934. He was born in East Boston, October 13, 1865. His early education was acquired in the schools of East Boston, he was graduated in medicine from the Harvard Medical School in 1888 and joined the Massachusetts Medical Society in that year. He was a member of the Council at the time of his death and a Fellow of the American Medical Association. At the meetings of the Council he took part in the debates and always showed an active interest in the proceedings.

Dr. Ensworth is survived by a sister and a nephew.

The Secretary read the names of the Nominating Committee by Districts and the following responded to their names and retired to make a list of nominations:

Barnstable: W. D. Kinney; *Berkshire*: H. J. Downey; *Bristol North*: W. H. Allen; *Bristol South*: E. F. Cody; *Essex North*: J. F. Burnham; *Hampden*: G. L. Schadt; *Hampshire*: J. G. Hanson; *Middlesex East*: R. R. Stratton; *Middlesex South*: A. W. Dudley; *Norfolk*: T. J. Murphy; *Norfolk South*: C. S. Adams; *Plymouth*: T. H. McCarthy; *Suffolk*: Lincoln Davis; *Worcester*: David Harrower; *Worcester North*: H. R. Nye.

Dr. D. N. Blakely, Norfolk, presented the report of the Committee on Membership and Finance, on Membership, as follows and it was accepted and its recommendations adopted.

REPORT OF THE COMMITTEE ON MEMBERSHIP AND FINANCE ON MEMBERSHIP

This Committee recommends:

1. That the following named fourteen Fellows be allowed to retire, under the provisions of Chapter I, Section 5, of the By-Laws:

1. Baker, Harry Beecher, Taunton, with remission of dues, 1932, 1933, 1934.
2. Bruce, Daniel Angus, Atlantic (Quincy), with remission of dues, 1934.
3. Colby, Fred Bennett, Rangeley, Maine, with remission of dues, 1933, 1934.
4. Dewey, Charles Gipson, Dorchester.
5. Dion, Thomas Joseph, Quincy, with remission of dues, 1934.
6. Duckering, William West, Dorchester.
7. Granger, Karle Henry, South Weymouth, with remission of dues, 1934.
8. Jackson, Alton Atwell, Everett.
9. Martin, George Forrest, Lowell.
10. Pillsbury, Ernest Dean, Sunmount, N. Y., with remission of dues, 1934.
11. Robinson, William Henry, Jamaica Plain, with remission of dues, 1934.
12. White, William Allen, Roxbury.
13. Whiting, George Washington Whitney, Medford, with remission of dues, 1934.
14. Wilson, Charles Oscar, Lowell, with remission of dues, 1934.

2. That dues of the following named two Fellows be remitted under the provisions of Chapter I, Section 6, of the By-Laws:

1. Brindisi, Rocco, Boston, 1934.
2. Hoey, Warren Henry, Newton Upper Falls, 1934.

3. That the following named seven Fellows be allowed to resign, under the provisions of Chapter I, Section 7, of the By-Laws:

1. Cosgrove, Joseph Justin, Atlantic, Maine, with remission of dues, 1933, 1934.
2. Ghormley, Ralph Kalb, Rochester, Minn., with remission of dues, 1933, 1934.
3. Jordan, William Riley, Richmond, Va., with remission of dues, 1933, 1934.
4. Komisar, Paul Stanislaw, Erie, Pa., with remission of dues, 1931, 1932, 1933, 1934.
5. McKeough, Wilfred Aloysius, Jamaica Plain, with remission of dues, 1934.
6. McQuade, Lewis Steele, Wollaston, with remission of dues, 1932, 1933, 1934.
7. Saeger, Ernest Tirrill, Boston, with remission of dues, 1932, 1933, 1934.

4. That the following named six Fellows be deprived of the privileges of Fellowship under the provisions of Chapter I, Section 8, Clause (a) of the By-Laws:

1. Boyd, James Van Wagner, Springfield.
2. Judkins, Charles Louville Mason, Lynn.
3. LeBeau, Raoul Joseph, Attleborough.
4. McMahon, William Thomas, Pittsfield.
5. Rosenthal, Joseph, Roxbury.
6. Smith, Forster Hanson, Lowell.

5. That the following named five Fellows be allowed to change their membership from one District Society to another without change of legal residence, under the provisions of Chapter III, Section 3, of the By-Laws:

One from Essex North to Essex South

1. Maddock, Stephen James, Boxford.

One from Essex North to Suffolk

1. McFee, William David, Haverhill.

One from Middlesex South to Suffolk

1. Richardson, Wyman, Newton Center.

One from Norfolk to Plymouth

1. Parker, George Leonard, Wrentham.

One from Worcester to Worcester North

*1. Bassow, George Joseph, Athol.

*Transferred to Worcester, June 5, 1933.

6. That Dr. Charles William Jackson, of Monson, a retired Fellow, be nominated to the House of Delegates for Affiliate Fellowship in the American Medical Association.

DAVID N. BLAKELY, *Chairman.*

He then offered his committee's report on Finance and it was adopted.

REPORT OF THE COMMITTEE ON MEMBERSHIP AND FINANCE ON FINANCE

This Committee recommends that the surety bond of the Treasurer for $15,000, which expires June 19, 1934, be renewed for one year from that date.

DAVID N. BLAKELY, *Chairman.*

Reports on three petitions for restoration to the privileges of fellowship were read by the Secretary as follows: for E. J. Grainger, F. S. Bennett and W. B. Riley. Each recommended that the petitioner be restored under the usual conditions, and each was accepted by vote. The report of a committee composed of Richard Collins, H. Q. Gallupe, and F. Van Nüys, recommending that the petition of I. F. Armstrong of Hudson be restored, had been referred to the Standing Committee on Ethics and Discipline by the Council, February 7, 1934 for an opinion. That committee, at a meeting on February 20, 1934, had reported that the report of the committee headed by Dr. Richard Collins in the case of I. F. Armstrong be approved. On being put to a vote Dr. Armstrong was restored under the customary conditions.

Petitions for restoration were received and committees to consider them appointed as follows:

For P. R. Oeser
J. F. Burnham, J. F. Howard, W. C. Farley.

For P. J. O'Day
R. A. Rice, F. H. Thompson, Jr., T. R. Donovan.

For H. S. Queen
G. E. Emery, E. R. Leib, R. J. Ward.

For G. L. Lemaitre
E. E. Cyr, N. J. Scarito, E. H. Ganley.

The Treasurer presented the following report, and it was accepted by vote:

REPORT OF THE TREASURER

Regarding the finances of the Society, for the first five months of this year, that is from January 1 to June 2, 1934, the treasurer reports as follows:

Annual dues, resident and non-resident, received by the treasurer, total $38,736. This is an increase of more than $3900 over the corresponding five months of 1933, the period, you will recall, of the "banking holiday", with bank failures. Income from securities of "General Fund" is $1743 which is a small increase over the corresponding months of 1933. Income from "Building Fund" is $934 compared with $947 for the five months of 1933. You may recall, also, that defaults came, in 1933, in interest of two securities held in the "Building Fund".

The Committee on Postgraduate Medical Instruction began the year with a cash balance of $2750; and the Council voted an additional appropriation of $1000 for expenses. This Committee ends the period, to this June, with a cash balance of about $3200 available for 1934-1935 activities.

In general, our Securities (bonds and notes) have shown further appreciation in market values during this year; indeed on several issues, prices are now abnormally high. During the first five months of this fiscal year when surplus cash accumulated from assessments, the treasurer, in order to bring in some income for the Society, has bought a number of short-term securities, yielding from 1¼ to 3½ per cent. He has also bought additional United States Government notes and other bonds, for longer investment. In his opinion, it is becoming more difficult to invest wisely our funds owing to uncertainties in the outlook for securities.

There has been only one unusual expense, not large, due to the coöperation of our Society with the Civil Works Administration of Massachusetts and the Federal Emergency Relief Administration.

CHARLES S. BUTLER, *Treasurer.*

Dr. A. S. Begg, Norfolk, a member of the Committee to revise the By-Laws spoke as follows:

Mr. President and Gentlemen, as you will remember, the Committee to revise the By-Laws was appointed at the October meeting of the Council. It held a series of meetings and presented at the February meeting a report. At that February meeting there were a number of suggestions made, although the Committee had attempted to get suggestions in before the meeting; those were rather slow in coming, and finally the Council at the February meeting voted to refer this report back to the Committee. This was done, and following the February meeting, Dr. Cheever, chairman, had a letter in the *New England Journal of Medicine* asking for suggestions. He also wrote to the presidents and secretaries of the various District Societies, asking for suggestions, and we had our final meeting at the very last possible moment so that we could get the report out for this particular meeting to-day.

We have received a number of suggestions, which we have carefully considered, and some of these have been included in this new draft, and some of them, for various reasons, were not included. This report which we now present contains two typographical errors that have been called to our attention. One of these is simply in the spelling of a word—on page 6. In the word "governed". The "e" and "n" should be interchanged. And in Section 7 on page 5 the word "blanks" appears in two places, and this should be changed to read "forms"—"printed forms" instead of "printed blanks". Those two corrections have been made in the By-Laws as they are now submitted.

A COUNCILOR: There is one additional typographical error on page 6, Section 1, where it says, "The Council shall consist". The second "s" is left out of "consist".

DR. BEGG: Oh, yes.

The Committee feels that, although since our final meeting there have been some suggestions made regarding changes in the By-Laws, it is impossible at a meeting of this kind to give proper consideration to some of those suggestions, and the Committee feels that it should ask that this report be adopted and these By-Laws be approved, and then if there are further changes they can be brought about through the provisions for amendments under Chapter IX, and I so move you.

Dr. H. F. R. Watts, Norfolk, spoke as follows:

Mr. President, I am instructed by the Councilors of the Norfolk District to bring to your attention one or two phases concerning the Committee on State and National Legislation. That Committee, as everyone recognizes, has done very valiant service. It has done tremendous service under very great difficulties in that the members have done it pretty much alone. As you know, in the past it has been the great complaint, and justly so, of the Committee on State and National Legislation that when hearings occurred at the State House they could get no one to come from the Society at large to help them in those hearings. That has been a crying shame.

During the past year the Norfolk District Medical Society has established a local Committee on State and National Legislation, whose aim it has been to aid and abet the efforts of the standing Committee on State and National Legislation, and I believe not without some material help. The Council of the Norfolk District feels that better work could be done if a larger number of Fellows of the Society could be given a job in this matter and in other matters. It feels also, incidentally, that if a larger number of men are Councilors than one in thirty, there would be a greater interest in the work of the Society. More men could be put to work and given a job.

This Committee on Legislation of the Norfolk District is so organized that the day before a State House hearing, for instance, by a system of "tom-tom" spreading of information on the telephone and distribution of the work among the Fellows, a large number of the Fellows were instructed to get down to the State House the following morning at 10 o'clock, and that has been done in many instances, with some help, I believe. Therefore, the Norfolk District would like, in the interest of decentralization of the work, that this standing committee be enlarged to include one member from every District Society in the State, making 19 members—a large committee, to be sure.

The second paragraph in Section 6 of the By-Laws, as existing and as now presented, seems to be a bit in conflict with that idea and with the endeavors of the Norfolk Committee. It says:

> "Any committees on state and national legislation appointed by District Societies shall be auxiliary to and under the control of this committee."

Any committee appointed by a District Medical Society must be responsible to its District Medical Society primarily; it cannot be under the control of the standing committee of the State Society. Therefore, Mr. President, I am prepared, by instruction from my colleagues in the Norfolk District, to offer this change which, if the Council cannot adopt at the present time, may take perhaps the regular course of either coming up later as an amendment, as suggested, or it might very well, it seems to me, be incorporated right now in Section 6:

> "The Committee on State and National Legislation shall consist of nineteen fellows, being one fellow to each District Society, together with the President, who shall be ex-officio its chairman. It shall uphold such measures . . ." and so on.

The rest of it can stand exactly as it is now. And in lieu of the second paragraph in which it is now prescribed that committees of local District Societies shall be under the control of the standing committee, at the suggestion of my colleagues I have drafted this paragraph:

> It shall encourage and foster the functioning of committees on legislative matters in each of the District Societies, to the end that District Society committees advise the Standing Committee on local conditions and requirements, that they coöperate in every way with the aims and purposes of, and through, the Standing Committee, but that they be, primarily, responsible to their local District Societies.

And the rest of the section is to remain as it is.

Dr. T. J. O'Brien, Suffolk, a member of the Standing Committee on State and National Legislation, made an informal report of the activities of that committee, explaining what had been done by the auxiliary committees during recent time. Dr. F. P. McCarthy, Norfolk, seconded Doctor Watts' motion. He thought that the Legislative Committee was concentrated around the City of Boston, and that it would be desirable to enlarge this committee; that the power of this committee should be spread throughout the State. Dr. S. B. Woodward, Worcester, said that as stated by Doctor O'Brien, he had been responsible while president for the appointment of the auxiliary committees which

consist of members in each of the eighteen districts. He thought that to get together nineteen men and try to accomplish anything would not be feasible, and he thought that the present Committee on State and National Legislation was not necessarily concentrated about Boston. Certainly it had one member from Worcester.

Dr. J. W. Bartol, Suffolk, spoke of his experience on three different committees to revise the By-Laws, the last one reporting in this very room six years ago to a day, when the By-Laws of 1928 were approved by the Council. The present committee to revise the By-Laws began its work last October, and brought in a careful revision. Many suggestions were given at the meeting last February. All Fellows had been urged to make suggestions, both by a letter in the *Journal* and by correspondence with the officers of the Society and of the District Societies. He thought that the By-Laws as presented by the Committee, with any minor changes that might be presented, ought to be approved by the Council at once; that if there were any amendments later, they could be taken care of in the customary manner by the provisions of Chapter IX of the By-Laws.

Dr. C. E. Mongan, Middlesex South, offered an amendment as follows: On page 5 in Section 5, beginning "Councilors in number equal to one for every thirty active and retired fellows and a majority fraction thereof, as of January first; . . .", he would like to amend that by substituting the word "twenty" for "thirty".

Dr. T. H. McCarthy, Plymouth, said that the Plymouth District had instructed him to move to modify the representation of Councilors from one in thirty to one in twenty-five, but he did not care to amend Doctor Mongan's motion. The amendment was seconded and put to a vote and passed. Doctor Watts' amendment was put to a voice vote and not accepted. On a rising vote it was plain that the noes prevailed by a sizable majority.

Dr. J. F. Burnham, Essex North, spoke as follows:

> Chapter VI, Section 3, the sixth paragraph of the amended By-Laws reads as follows:
>
> "Under the direction of the Committee on Publications he (the secretary) shall issue annually, as soon as possible after the first of January, to the officers of the general Society, of the District Societies, to the Councilors, and to such other Fellows in good standing as make application at the headquarters of the Society, a directory of the officers and Fellows of the Society."
>
> That supersedes the words "sent to the Fellows who are not in arrears." That, as you see, limits the distribution of our directory very, very much, and I think it is an error. I think the men in the trenches should be recognized. For many years we have had a directory which is the best directory of any published by any State Society in the United States and is a wonderful credit to our Secretary. [Applause.] It should be in the hands of every man who pays his dues.
>
> Some of the reasons are: First, it will help a man who sends a case to another town to be able to send it to a Fellow of the Society. If a man wishes to call a consultant, he can call a consultant from that list with more certainty than he can call from a list that contains every doctor who may be in Massachusetts. It is a splendid advertisement of our Society.
>
> We know there is some complaint among the men in the trenches that the Society is not doing much for them. We who are on the inside all know that that is not the fact. But here is one definite evidence that can be brought up that the Society has struck away one of the privileges which it has given to the practitioners throughout the State ever since the directory was published.

Doctor Begg stated that his committee had received the suggestions about the Directory and that they did not wish to see it abandoned, but were trying to save money for the Society by restricting the distribution. Doctor Burnham's motion having been seconded was passed by a unanimous vote.

The By-Laws as thus amended were approved without dissent.

The Nominating Committee having placed the following names on the blackboard, and there being no further nominations from the floor, on motion duly seconded, the Councilors were requested not to vote and the Secretary to cast one ballot for the names on the blackboard:

For President: William H. Robey, Boston.
For Vice-President: Philemon E. Truesdale, Fall River.
For Secretary: Walter L. Burrage, Brookline.
For Treasurer: Charles S. Butler, Boston.
For Orator: Brace W. Paddock, Pittsfield.

The Secretary having cast the ballot, the President announced the above officers and orator elected.

The Council adjourned for the Cotting Luncheon at 1:10 P.M.

The Council reassembled in the same room at 2:00 P.M., President Robey in the chair. Dr. R. I. Lee, Suffolk, Chairman of the Committee on Publications, presented an informal report, saying that the *Journal* was in excellent condition financially and also in the scientific and literary material in hand. It was well known that the credit for its successful conduct was due to the editorial staff and to the Board of Editorial Advisors, but particular credit should be given to the Editor-in-Chief, who has served so many years with a reduced salary.

In the absence of the Chairman, the Report of the Committee on Ethics and Discipline was read in abstract by the Secretary. (See Appendix No. 1.) The report was accepted.

Dr. Reginald Fitz, Suffolk, read the Report of the Committee on Medical Education and Medical Diplomas. (See Appendix No. 2.) The report was accepted and its recommendations adopted, including a new list of medical schools and colleges, diplomas from which are recognized by the Council, and a prize of $50 for the best written case report by an interne.

Dr. Dwight O'Hara, Middlesex South, presented two reports for the Committee on Public Health. (See Appendix No. 3.) The reports were accepted. Dr. T. J. O'Brien, Suffolk, read the report of the Committee on State and National Legislation, and it was accepted. (See Appendix No. 4.) Dr. E. D. Gardner, Bristol South, read the report of the Committee on Malpractice Defence and it was accepted. (See Appendix No. 5.) Dr. T. J. O'Brien, Suffolk, read the report of the Committee on Permanent Home, and it was accepted. (See Appendix No. 6.) Dr. W. P. Bowers, Worcester, stated as regards the New England Medical Council, that the New Hampshire and Rhode Island members a year ago had been disinclined to become associated with the other State Societies in meeting an equal proportion of the assessment for maintaining the work. At the last meeting of the New Hampshire Medical Society there was exhibited a definite desire to have this organization kept alive, but it has seemed advisable, until there should be a more definite unanimity of opinion with reference to the functions of that Council, that the operation should be suspended until that spirit is manifested.

Dr. F. R. Ober read the report of the Committee on Postgraduate Medical Instruction. It was accepted with the thanks of the Council and a vote that the Committee be continued. (See Appendix No. 7.)

The President asked the Vice-President, Doctor Truesdale, to take the Chair. Dr. Robey took the floor and explained the report of the Committee on Public Relations as follows:

Mr. Chairman, the Committee on Public Relations is now in its third year. The large committee has held three meetings during the past year and the sub-committee several more. The small committee has had as its chairman Dr. Walter A. Lane. The attendance at the meetings has been very large, I should say practically 100 per cent, and the men have come from all parts of the State for each meeting of our Committee.

The work of the Committee has been wide in scope in the number of topics that have been considered. Unfortunately, the results are small, but that is not the fault of the Committee but simply because it has met with insuperable difficulties in the matters which it has had to handle. Probably no Committee in the Society has had so difficult a piece of work to perform as has this Committee on Public Relations.

I simply want to call to your attention, gentlemen, one or two points in this printed report which is in your hands. First, Question 3 on page 4. (See Appendix No. 8.) I am just going to read that so it will be in your minds. This has to do with industrial accident insurance. I may say, as a preface to this, that we have had another conference this year with representatives of the claim agents and insurance companies, and, while I think they enjoy meeting with us, they are really in the same position we are. Their acts are fixed by law, as are ours, but there are certain things which the Committee can do. And this third question on page 4 is:

"Is your staff in favor of recommending to the trustees of your hospital that any injured patient, coming under the provisions of the Workmen's Compensation Act, shall be received on a private or semi-private base charge, shall be allowed to choose from the staff a physician who shall be responsible for his treatment and care, and who shall be eligible to make reasonable charges for his services?"

There is no need of reading the list of the hospitals in the questionnaire which was sent out to a large number of them. As a result of this, the Committee on Public Relations has recommended as follows (Page 4, bottom):

"We recommend that all patients who come under the provision of the Workmen's Industrial Compensation Act on admission to a hospital be referred to private or semi-private rooms and that the patient be required to choose a physician who will be responsible for his care and treatment. The Secretary of the Massachusetts Medical Society shall inform by letter the trustees and staff of each hospital, admitting Industrial Accident cases to its facilities, of the action of the Council of the Massachusetts Medical Society."

DR. WOODWARD: I suggest substituting the word "asked" for the word "required".

PRESIDENT ROBEY: Yes, substituting "asked" for "required". That was the particular advice, I think, of the Attorney-General.

The next few pages have to deal with the bill introduced by the State Board of Public Health to establish a board for the examination of cases of silicosis and tuberculosis among workers. That was heard by three committees, the various representatives of the State and National Legislation Committee, the Public Rela-

tions Committee, and Committees of two or three Medical Societies, as well as by the Tuberculosis Section of the Massachusetts Medical Society and the New England Roentgenological Society. The result of it all was that we convinced the three committees that no legislation was necessary because the bill had gone through the Senate and no legislation was considered necessary. It has all gone over, and Bill No. 1350 now has been given up. There are two bills, 1551 and 1553, which now have to do with admissions to the Department of Industry and Labor, in which they admonish its members to try if possible to introduce more and more the methods of protecting the workers from dust.

There are several other matters in this report, gentlemen, but they do not need to be taken up here, or to consume time, because you can read what some of the activities of the Committee have been.

I move you, sir, that the report of this Committee be accepted by the Council, and placed on file.

The Vice-President spoke in praise of the report, and Dr. G. H. Bigelow, Suffolk, thought the report was disappointing. On motion by Doctor Mongan, the report was accepted and its recommendations adopted.

Dr. A. S. Begg presented some resolutions of the Norfolk District as regards free treatment privileges in municipal and endowed charitable hospitals. (See Appendix No. 9.) The resolutions were adopted by vote.

Dr. H. P. Towle, Suffolk, spoke as follows:

When the Massachusetts Medical Society was young and the membership small, the old-time method of one program and one meeting covered every need. When, however, the membership grew larger and knowledge in medicine increased, the old method became cumbersome and inconvenient. The Section was the natural and inevitable result. The Society recognized the situation and incorporated into its By-Laws a provision for creating new Sections—Article 6, Chapter IV. To-day there are six Sections. Experience has taught that the educational value of the Section method to the general membership is immeasurably greater than that of the one program method. The papers are better prepared and, therefore, more authoritative and interesting, and there is no waste of time for the members attending the Annual Meeting.

Since the dermatologists and syphilologists banded themselves together in 1915, the interest in dermatology and syphilis has increased and spread until to-day there are more than four times as many professedly interested in those subjects as there were in 1915. They feel now that the time has come when Dermatology and Syphilis should be represented at the Annual Meeting of the Massachusetts Medical Society by a Section of Dermatology and Syphilology for the further advancement of knowledge in these fields but particularly for the more adequate instruction of the medical public. We, therefore, ask your support in the establishment of such a Section under Article 6 of Chapter IV. Therefore I make the following motion:

That the Massachusetts Medical Society, here in Council assembled, hereby authorizes and creates a Section of Dermatology and Syphilology, with all the rights, powers, and privileges of the other constituent Sections of the Society, to meet with the Society at the Annual Meeting of 1935 and annually thereafter.

This was discussed by Doctor Stetson of Franklin and Doctor Mongan, and the motion was passed. On nomination by Dr. J. H. Blaisdell, Middlesex East, the following officers of the new Section were appointed: *Chairman:* Dr. Charles J. White, Boston; *Secretary:* Dr. William P. Boardman, Boston.

Dr. W. A. R. Chapin, Hampden, presented the following resolution of the Hampden District Medical Society:

PROPOSED RESOLUTION BY THE LEGISLATIVE COMMITTEE OF THE HAMPDEN DISTRICT MEDICAL SOCIETY

Whereas at a meeting of the Hampden District Medical Society held in Springfield on the 4th day of April, 1934, the matter of proper medical legislation in this State was discussed, and

Whereas the State of Massachusetts is the only state in the Union which allows graduates of Class C schools to practice therein, and

Whereas this condition draws to Massachusetts all Class C graduates who sooner or later may pass the State Board here with the result that in time Massachusetts will become a Class C state in practice if not in theory while every other state is Class A, and

Whereas for some time past all efforts made to remedy this condition have failed, and

Whereas the growing complications of hospital affiliations are becoming more and more embarrassing to those institutions who would hold to established standards and force new registrants in medicine, though passed by the Board as fit but who have diplomas from Class C schools, to gravitate to hospitals whose standards are lax, thus encouraging low hospital standards and depriving these new men of inspirational medical contacts and proper opportunity for advancement in knowledge, and

Whereas this situation affects not only the people of Massachusetts as patients but more particularly the entire medical population, Doctors, nurses, Public Health workers and Hospitals, and

Whereas a number of graduates of Massachusetts Class C schools residing in this vicinity are anxious that remedial legislation be passed forcing their schools to attain a Class A rating, and

Whereas these men have signified their wish to forward the purpose of House Bill No. 118 that would give the Board of Registration in Medicine the power to determine from what schools graduates would be acceptable for examination, provided after such bill is passed the Massachusetts Medical Society will go on record as being willing to aid their

schools in attaining Class A rating and will not in any way oppose the attainment of this rating if the school authorities meet the requirements of Class A standards,

Now, Therefore, Be It Resolved that this society recommend to the Massachusetts Medical Society at its next convention in June, 1934, the adoption of a resolution making effective the thoughts contained herein, assuring these men of the society's coöperation.

Recommended by:
W. A. R. CHAPIN,
A. M. GLICKMAN,
R. R. MEUNIER,
Legislative Committee.

April 24, 1934.

This was discussed by Dr. J. M. Birnie, Hampden, and by invitation by Dr. E. E. W. Walker, Superintendent of the Springfield Hospital, which is a Class A hospital approved for internes by the American Medical Association. He had had difficulty in admitting as internes graduates of the Middlesex College of Medicine and Surgery, a Class C school. On motion by Doctor Birnie it was voted to refer this resolution to the following committee of five to report at the October meeting of the Council: Reginald Fitz, *Chairman;* C. H. Lawrence, Jr., C. A. Sparrow, E. S. Calderwood, and A. S. Begg.

The Chair nominated and the Council appointed the following committees for the ensuing year:

STANDING COMMITTEES

COMMITTEE OF ARRANGEMENTS
W. M. Shedden, *Chairman;* W. R. Morrison, Horatio Rogers, W. S. Burrage, R. P. Stetson.

COMMITTEE ON PUBLICATIONS
R. I. Lee, *Chairman;* Homer Gage, R. B. Osgood, R. M. Smith, F. H. Lahey.

COMMITTEE ON MEMBERSHIP AND FINANCE
D. N. Blakely, *Chairman;* Gilman Osgood, G. C. Caner, J. E. Fish, H. F. Newton.

COMMITTEE ON ETHICS AND DISCIPLINE
David Cheever, *Chairman;* W. D. Ruston, S. F. McKeen, A. C. Smith, R. L. DeNormandie.

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL DIPLOMAS
Reginald Fitz, *Chairman;* C. H. Lawrence, C. A. Sparrow, E. S. Calderwood, A. S. Begg.

COMMITTEE ON STATE AND NATIONAL LEGISLATION
W. H. Robey, *Chairman;* T. J. O'Brien, F. E. Jones, A. W. Marsh, Shields Warren.

COMMITTEE ON PUBLIC HEALTH
Dwight O'Hara, *Chairman;* E. F. Cody, F. G. Curtis, Gerald Hoeffel, G. D. Henderson.

COMMITTEE ON MALPRACTICE DEFENCE
F. G. Balch, *Chairman;* E. D. Gardner, F. B. Sweet, R. P. Watkins, A. W. Allen.

COMMITTEE ON PERMANENT HOME
T. J. O'Brien, *Chairman;* S. B. Woodward, C. G. Mixter, J. M. Birnie, R. B. Greenough.

There being no further business it was voted to adjourn at 3:10 P.M.

WALTER L. BURRAGE,
Secretary.

APPENDIX TO THE PROCEEDINGS OF THE COUNCIL

APPENDIX NO. 1

REPORT OF THE COMMITTEE ON ETHICS AND DISCIPLINE

The Committee held 8 meetings during the year (at only 1 of which was a single member absent) and conducted 7 hearings:—the cases of 31 Fellows who were alleged to have violated the Code of Ethics were considered; letters of remonstrance were written to 17; one was recommended to the President for admonition; one was recommended for expulsion after joint action by the Committee on Membership and Finance and the Committee on Ethics and Discipline, under the provisions of Chapter I, Section 8, Clause (C) of the By-Laws; no one was brought before a Board of Trial. Among the alleged offenses, unethical publicity and advertising were by all odds the most numerous;—among others may be mentioned the charging of exorbitant fees, alleged commission of abortion, the giving of false and misleading testimony in Court, conspiracy to steal from insurance companies, and unprofessional conduct toward patients or other physicians.

While the above represents in broad outline the work of the Committee as a whole, it should be known that most of the essential and time-consuming work is transacted by personal interviews, conferences and correspondence with Fellows of the Society by the Chairman and Secretary, and by personal investigations of the sources and credibility of evidence by the Chairman or by some other member of the Committee. It is our impression that the help of the Committee as an arbiter of behavior and as a means of assistance for our Fellows is much more widely sought than was formerly the case. Certainly no week goes by and rarely a two or three day period without a personal or telephonic call to the Chairman for advice or for a ruling on the wisdom, good taste, or ethical character of some course of action. Many of these problems are presented by laymen who have grievances against Fellows of the Society, or who are anxious to establish schemes by which professional medical services may be "sold" to the public,—of course with due pecuniary profit to the lay jobber. It is scarcely an exaggeration to say that the Committee could employ with advantage the full time of a skilled agent or investigator together with the occasional services of a lawyer, if it would aspire adequately to examine and appraise all the problems brought before it. Some of these problems may be more definitely noted.

In two instances, during the year, the Committee has taken cognizance of alleged exorbitant fees, in accordance with the policy enunciated in recent annual reports, to the effect that while our Code of Ethics wisely states that a physician, by arrangement with his patient beforehand, may attach any value he chooses to his services, nevertheless the charging of fees totally out of proportion to the value of services rendered, or to the patient's means, or to both, undermines the confidence of the public in our profession, tends to reduce it to the level of a trade and drives people to public clinics, cultists, or self-medication. An example of what is consid-

ered by the Committee to be an exorbitant charge, is the bill of $4740, rendered by a Fellow to the estate of a deceased patient, whom he had attended for 3½ months. The total estate was about $12,000. The bill showed that 10 incisions of superficial abscesses under novocaine were classified as operations worth $150 each, that 45 routine examinations of urine were considered necessary at $8 each, that white blood counts were worth $10; that 114 "bed-side examinations" at $10 each were differentiated from 87 "special treatments of wounds" at $15 each. The Committee felt that these charges could be justly characterized as raiding an estate, and after a hearing, voted that the Fellow be admonished by the President. Another instance was the bill for $2590 for a not unusual rhinological operation, rendered by a Fellow to a young married man, unemployed, whose income was $4,000. It was shown that the patient had made a conscientious effort to find out beforehand what the operation would cost, and thought that he had received assurance that it would not exceed $1,000, which seemed to the Committee a very generous figure. In this case the Committee wrote a friendly letter to the physician expressing its conviction that he undoubtedly had a very exaggerated idea of the patient's resources, and pointing out the harm that the profession might suffer from acquiring a reputation for mercenary rather than altruistic motives.

It is hoped that the Society realizes that while an investigation by our Committee, may suggest, to the uninitiated, a presumption of irregular or wrongful actions by a Fellow, the fact is that a large part of our work is concerned with the protection and exoneration of our Fellows from unfounded accusations and criticism. When a Fellow is found guilty by other authority, of misdemeanors incompatible with the ethical standards of our Society, we do not accept such a verdict if any doubt of its justice exists. A case which has interested us and on which we have spent much time this winter is that of a hitherto respected practitioner, a former member of this Council, who is at this moment serving 2½ to 4 years in the State prison, for "administering a drug with intent to cause a miscarriage." The physician and his patient emphatically assert their innocence, and the evidence on which conviction was based seems dubious to the Committee. These facts, together with the apparently accepted disbelief on the part of the medical profession that any drug exists which will produce miscarriage, and the severity of the sentence, in an age when manifest malefactors, on parole or with suspended sentences, go unpunished, moved the Committee to make an investigation which is still going on; but in the meantime, in view of the physician's conviction and sentence, and the consequent revocation of his license to practice, the Committee feels obliged to recommend his expulsion under Chapter I, Section 8, Clause (C) of the By-Laws.

The modern trend toward economic reorganization of medical practice and the willingness of laymen to manage our affairs for us were illustrated by schemes which were brought to our attention. A business man, strongly supported by one of our Fellows, allegedly representing a group of physicians, proposed a plan by which he should establish an agency to secure for the employees of great corporations and their families satisfactory medical services at reasonable rates from a group of competent physicians representing the various specialties. The officers of the corporations were to advise their employees of this service and urge them to make use of it;—the agent's remuneration was to be on a percentage basis of fees collected. This plan seemed to our Committee to comprise numerous unethical features, including a type of contract practice, the obtaining of patients by a form of advertising, the division of fees and the loss of the independent relations of physician and patient. The Committee ruled that the enrollment of Fellows of the Society in this plan would be contrary to the spirit of the Code of Ethics and to the best interests of the profession. Another business man proposed a plan along familiar lines which the Committee has disapproved on other occasions: namely, the organization of a stock company to supply under contract medical services by physicians for a fixed sum per year, thus destroying the free relationship of physician and patient, obtaining patients by advertising, and diverting to lay promoters a large part of the fees paid for medical service. The Committee disapproved of participation in the plan by Fellows of the Massachusetts Medical Society.

One form of abuse of medical ethics,—the improper testimony of physicians in suits for malpractice, has not come to the attention of the Committee during this year, or indeed in recent years, probably because of the efficient way in which the Committee on Malpractice Defense handles its problems. Another phase of this subject, however, is of considerable interest, namely, whether or not our Society, through the Committee on Ethics and Discipline or otherwise, should take cognizance of the character of testimony offered by Fellows in courts of law, especially in criminal cases. A physician reading in the daily press reports of "expert" testimony of medical witnesses, brought out under the skilful guidance of counsel for the defense, can hardly fail, at times, to be disgusted by its partiality and by its perversion of medical learning to thwart the ends of justice. Yet the intent and motive of any criticism or disciplinary action on the part of the organized profession could be similarly misconstrued and perverted so as to create serious prejudice in the minds of jury and public alike, against our Society. It is a situation filled with dynamite, to be handled, if at all, with great circumspection.

Attention has repeatedly been called in these reports to the difficulty of adjusting our traditional avoidance of anything which may savor of personal advertising, to the modern craze for publicity, which forces on us physicians,—both willing and unwilling, the attention of the newspaper and radio audience. It becomes more and more an accepted doctrine that the medical profession must "sell" itself to the public, and educate the people in personal as well as in public health matters; to this end public lectures, radio broadcasts and newspaper write-ups on medical topics have become every-day occurrences. The wisdom of a good deal of this propaganda is doubted by thoughtful observers, but it appears certainly desirable that the dignity of the profession should be preserved by the discouraging of personal publicity. Fellows who seek publicity under various guises in the press or on the air and who are remonstrated with, can point with some justice to the example of others of the profession who under the guise of giving public instruction are brought even more effectively to public notice, and can inquire as to what the difference may be. The Committee on Ethics and Discipline has long maintained that addresses on medical topics for public instruction should be signed or sponsored by a committee or officer of a medical society or school rather than by an individual, or should be given by a physician not engaged in local private practice, and should be on general topics rather than on the diagnosis and treatment of concrete symptoms of disease, and that every effort should be made to prevent the inclusion by reporters of laudatory puffs about the writer. The Committee acknowledges

with pleasure the action of three Fellows of the Society who, on having their attention called to criticism by other Fellows of offensively laudatory "write-ups" of their work, have written letters to the *New England Journal of Medicine* disavowing any responsibility therefor and supporting the efforts of the Committee to discourage such publicity.

An oft-recurring question concerns the propriety of consultations with or participation in the activities of irregular practitioners of the healing art comprehended under the term "cultists". The Committee disapproves of consultations between Fellows of the Massachusetts Medical Society and cultists. A consultation implies a conference between persons holding similar views and concepts of the basic scientific principles underlying a problem; if their views are irreconcilable and fundamentally different, no true consultation can be possible. Our Code of Ethics states that "physicians should encourage sound medical learning, and uphold in the community correct views of the powers and limitations of the science and art of medicine". It seems certain that a consultation between a scientific and regularly trained physician and a cultist cannot fail to lend countenance to and dignify such a person and his cult. Naturally this expression of opinion by the Committee should not deter a Fellow from offering his help in case of emergency, at the same time letting it be known that he is not in sympathy with the cultist's creed. The Committee holds a similar view about the giving of lectures or talks by our Fellows upon medical topics, before gatherings of irregular practitioners:—surely such an act cannot fail to dignify and encourage the latter.

A somewhat similar problem is presented by the giving of lectures by our Fellows to students in schools whose standards of education are so low that their diplomas are not recognized by our Council. This has been disapproved by the Committee, on the ground that such a course does not "encourage sound medical learning". In the case of a "club" composed of students and graduates of such an institution but having no official connection with it, the Committee realizing that under certain circumstances, these graduates may be eligible for Fellowship in our Society, ruled that a Fellow would not be criticized as unethical if he lectured before it, but that it considered such action unwise, especially in view of the fact that there was evidence that the giving of such lectures by our Fellows was offered as evidence of its good standing, by the authorities of the school in question.

One of the unfortunate aspects of the present economic depression is that the actual or threatened financial distress of large numbers of our profession leads inevitably to irregularities of conduct and deviations from the highest standards of practice, if such relaxation seems to promise more financial return. It is much to the credit of our Fellows that in so few instances have such temptations been yielded to.

DAVID CHEEVER, *Chairman*,
WARREN D. RUSTON,
SYLVESTER F. MCKEEN,
ALFRED C. SMITH,
ROBERT L. DENORMANDIE.

APPENDIX NO. 2

REPORT OF THE COMMITTEE ON MEDICAL EDUCATION AND MEDICAL DIPLOMAS

During the past year this Committee has held four meetings. Two have been held for the purpose of scrutinizing the diplomas of candidates for fellowship in the Society who are graduates of medical colleges unrecognized by the Council; and two for the purpose of discussing matters other than routine pertaining to problems on medical education and diplomas.

The Committee has examined by personal interview in the neighborhood of thirty candidates for fellowship in the Society. Twenty-one of these, their diplomas proving acceptable to the Committee, have passed the examinations of the Censors and have been permitted to join the Massachusetts Medical Society. During the past year, therefore, nine per cent of the new Fellows are graduates from unrecognized schools.

The Committee has meticulously studied Section 5 in Chapter VII of the revised By-Laws of the Society and believes that the description of our duties here laid down does much to strengthen the Committee's authority. We are especially impressed with the second paragraph:

> "It (the Committee) shall have power to recognize a medical diploma from a foreign medical school or college or from a domestic school or college not on the list recognized by the Council, when such a diploma is presented by an applicant who has practiced for a minimum of five years, offers proof to the Committee that he is a capable and conscientious practitioner of medicine, and is recommended in confidential communications by a number of his colleagues who are Fellows of the Society. The medical diploma and written recommendations of colleagues shall be sent by the district secretary to the chairman of the Committee at least three weeks before any given examination. The Committee shall interview personally all such applicants for fellowship."

According to our interpretation of this paragraph, graduates from unrecognized medical colleges who in future wish to become Fellows of the Society must be better known than heretofore and must clearly demonstrate their capabilities not only to the examining Censors but also to the Committee on Medical Education and Medical Diplomas before they can be elected. Moreover, they must be recommended by a number of impartial Fellows through the Secretaries of the various District Societies. This proceeding should do away with the valueless type of commendatory letters which candidates have been in the habit of obtaining from uncritical friends, and should make the attainment of fellowship in the Society more difficult and therefore more valuable for candidates of uncertain medical education.

Anticipating that as soon as the revised By-Laws become effectual the Council may at once direct revision of the list of medical schools and colleges to be recognized by that body, we have completed such a revision. The Committee on Medical Education and Medical Diplomas recommends that the following list of medical schools and colleges now be recognized by the Council.

*University of Alabama School of Medicine.
University of Arkansas School of Medicine.
University of California Medical School.
University of Southern California School of Medicine.
Stanford University School of Medicine.
College of Medical Evangelists.
University of Colorado School of Medicine.
Yale University School of Medicine.
George Washington University School of Medicine.
Georgetown University School of Medicine.
Howard University College of Medicine.
†University of Georgia School of Medicine.

Emory University School of Medicine.
Rush Medical College, University of Chicago.
The School of Medicine of the Division of the Biological Sciences, University of Chicago.
Northwestern University Medical School.
University of Illinois College of Medicine.
Loyola University School of Medicine.
Indiana University School of Medicine.
State University of Iowa College of Medicine.
University of Kansas School of Medicine.
University of Louisville School of Medicine.
Tulane University of Louisiana School of Medicine.
Louisiana State University Medical Center.
University of Maryland School of Medicine and College of Physicians and Surgeons.
Johns Hopkins University School of Medicine.
Harvard University Medical School.
Boston University School of Medicine.
Tufts College Medical School.
University of Michigan Medical School.
Wayne University, College of Medicine.
University of Minnesota Medical School.
*University of Mississippi School of Medicine.
Washington University School of Medicine.
*University of Missouri School of Medicine.
St. Louis University School of Medicine.
University of Nebraska College of Medicine.
Creighton University School of Medicine.
*Dartmouth Medical School.
Columbia University College of Physicians and Surgeons.
Albany Medical College.
University of Buffalo School of Medicine.
Long Island College of Medicine.
New York Homeopathic Medical College and Flower Hospital.
Syracuse University College of Medicine.
New York University, University and Bellevue Hospital Medical College.
Cornell University Medical College.
University of Rochester School of Medicine.
*University of North Carolina School of Medicine.
*Wake Forest College School of Medicine.
Duke University School of Medicine.
*University of North Dakota School of Medicine.
Western Reserve University School of Medicine.
Ohio State University College of Medicine.
University of Cincinnati College of Medicine.
University of Oklahoma School of Medicine.
University of Oregon Medical School.
University of Pennsylvania School of Medicine.
Jefferson Medical College.
Woman's Medical College of Pennsylvania.
Hahnemann Medical College.
University of Pittsburgh School of Medicine.
Temple University School of Medicine.
Medical College of the State of South Carolina.
*University of South Dakota School of Medicine.
Vanderbilt University School of Medicine.
University of Tennessee College of Medicine.
Meharry Medical College.
University of Texas School of Medicine.
Baylor University College of Medicine.
*University of Utah School of Medicine.
University of Vermont College of Medicine.
University of Virginia Department of Medicine.
Medical College of Virginia.
*West Virginia University School of Medicine.
University of Wisconsin Medical School.
Marquette University School of Medicine.
University of Alberta Faculty of Medicine.
University of Manitoba Faculty of Medicine.
Dalhousie University Faculty of Medicine.
University of Toronto Faculty of Medicine.
Queen's University Faculty of Medicine.
University of Western Ontario Medical School.
McGill University Faculty of Medicine.
University of Montreal Faculty of Medicine.
Laval University Faculty of Medicine.
*University of Saskatchewan School of Medical Sciences.

*These schools offer only first two years of medical course, no longer awarding medical diplomas.

†Only diplomas previous to 1934 are to be recognized.

Two members of the Committee attended the meeting of the Association of American Medical Colleges held in Rochester, Minnesota last fall, and the Congress on Medical Education, Licensure and Hospitals of the American Medical Association held in Chicago in February. The Committee continues to consider it an important duty for its members to attend such meetings as regularly as possible, not only to be able to inform Fellows at home regarding any interesting new developments that may come forth at such gatherings, but also so that our experience on matters dealing with Medical Education and Medical Diplomas may be of help to other State Medical Societies throughout the country.

The Committee regards with great pride the progressive and public-spirited attitude assumed by the Society in questions pertaining to medical education. We feel that the experiment in postgraduate instruction carried out by the Society during the past year has been notably successful and is an undertaking worth carrying forward. The Committee on Medical Education and Medical Diplomas by virtue of having two members on the Committee on Postgraduate Medical Instruction has been in active liaison with the latter Committee during the entire year and continues eager to do all in its power to establish in Massachusetts a well-organized method by which the Society shall offer its Fellows continuously improving opportunities to keep up with the increasing ramifications of medical knowledge.

We believe that there is one important aspect of postgraduate instruction in Massachusetts so far unconsidered which deserves study. This deals with the training of interns. We have made a preliminary survey of Massachusetts internships and already have reported the results of the survey to the Council. We ask for authority to study further the internships available to young doctors in Massachusetts, having in mind inspection of all hospitals in the state which wish to go on record as being properly qualified to offer intern training. We believe that it would be very advantageous to medical students if the internships available in Massachusetts could be formally classified and described by the Society and that systematic inspection from time to time would be advantageous to the various hospitals.

Finally, we advocate that the Society be moved to offer an annual prize of $50 for the best written and most comprehensive case report submitted by interns holding any of the rotating internships now offered in Massachusetts and approved by the American Medical Association. Such a prize would do much to stimulate medical writing among younger men and would help to disseminate throughout the State the importance and interest of keeping abreast of medical literature. The prize each year might be awarded by an editorial committee appointed by the President including himself or his representative, a member of the Committee on Publications, a member of the Committee on Medical Education and Medical Diplomas, a member of the Editorial Board of the *New England Journal of Medicine* and a member representing the President of the Boston Medical Library.

REGINALD FITZ, *Chairman*,
C. H. LAWRENCE,
C. A. SPARROW,
E. S. CALDERWOOD,
A. S. BEGG.

APPENDIX NO. 3

Report of the Committee on Public Health

During the past year the Committee on Public Health has been studying the periodic health examination. The Division of Adult Hygiene of the State Department of Health precipitated this study by asking the Committee to coöperate in an educational campaign intended to popularize health examinations in this State.

The Committee published a communication on the subject in the January 25 issue of the *New England Journal of Medicine*. This communication was based upon the invited opinions of members of the Council, and was drafted with the coöperation of the State Department of Public Health. A recent poll of the members of this Council reveals that the communication as printed was satisfactory to 90 per cent of the members replying. In so far as the Council represents the Fellows of the Society, then, the Committee feels that for the present this communication can be accepted as it stands.

On the other hand, the Public Health Council has advised the State Department of Public Health that "The desirability of periodic health examinations annually versus a physical examination to clear up indefinite or minor ailments or symptoms was discussed at length and it was the consensus of opinion of the medical members of the Council that the annual periodic health examination formerly advocated by the Department is still desirable and the Department should continue to recommend it whenever the opinion of the Department is requested." This leaves the State Department in a somewhat awkward position.

In the *American Medical Association Bulletin* for March of this year there is a paper on the subject by Dr. Bauer, who concludes as follows: "The periodic health examination seems to be, at this time, in a status which all movements reach sooner or later. The initial stage of enthusiasm for a new idea has been passed. A lull has come. Physicians are doubting, considering, questioning. It is a wholesome indication. If the conception of regular health examinations at intervals is sound, it will emerge from this phase and be carried forward; if it is unsound, it will die."

Dwight O'Hara, *Chairman*,
E. F. Cody,
F. G. Curtis,
G. N. Hoeffel,
G. D. Henderson.

Report of Committee on Public Education

This Committee has continued to coöperate with the State Department of Public Health in the joint sponsorship of weekly broadcasts of a popular variety on medical topics. A recent survey by the Division of Adult Hygiene indicated that there are approximately forty thousand people listening to these broadcasts each week. Other groups than ours have broadcast similar series—in some cases quite as good as our own. When this was the case we could only be pleased that the work was so well done.

The Harvard Medical School has continued its public lectures with their associated newspaper publicity, sometimes of a highly personal nature. Probably anyone who toys with "the Delilah of the press" will find, as Osler said, that "sooner or later she is sure to play the harlot."

The rivalry between the broadcasting companies and the newspapers, which has been referred to in our previous reports, has during the past few months been developed to the point where the broadcasting companies are now gathering their own news items, instead of depending upon the newspapers for this material as heretofore. The time when we might use the same copy for both radio and newspaper publicity has therefore probably passed.

The Committee has no desire to expand its activities to include the newspapers, but it is interested in the effectiveness of any method used to influence the public. Some of its members question the worth of any of these methods. The profession is now dipping its toes in the waters of publicity. Some day it must decide whether it is going to go in all over or go back and put on its clothes.

The Committee has referred in previous reports to the "better health" theme which has woven itself into the radio programs of the commercial purveyors. Within the past few days we have been asked to present the resolutions concerning those abuses to the Society. This we plan to do at the annual meeting of the Society tomorrow.

Dwight O'Hara, *Chairman*.

APPENDIX NO. 4

Report of the Committee on State and National Legislation

After the Annual Meeting of 1933, an educational campaign was planned and the Chairman, with a member of the committee, visited sixteen cities throughout the State in the summer and fall of that year and six cities in 1934. District medical societies, hospital staffs and medical groups were addressed and methods of organization were specifically outlined. The value of personal contact with influential citizens and especially with local Legislators was emphasized. The aid of allied professions, as the State organizations of dentistry, pharmacy and nursing was obtained for our mutual advantage.

When the Legislature convened in January, 1934, the various bills were studied and a definite action was decided upon each one. Forty-six bills were introduced which would have influenced the teaching of medicine or the practice of the healing art in this State. Members of our committee attended fourteen hearings during the present session.

Our present economic problems have caused the average physician to become "politically minded". We refer particularly to the physician with a small equity in a home; with children at college or with heavy overhead expenses. We kept in close contact with federal and civic bills drawn to influence compensation or payment to physicians for welfare service.

The interest taken by physicians was state-wide and every local legislative committee is worthy of honorable mention for its active coöperation. Our method of having groups of physicians accompanied by influential citizens of a community present the principles involved in each important bill to their Legislators has been most satisfactory and we advise the continuance of this plan. Our By-Laws state that the Committee on State and National Legislation "shall oppose such measures as it may deem contrary to the public welfare and support and initiate measures which promise to advance a higher standard of medicine and promote the public welfare". We therefore recommend that no bills be introduced by members of the Massachusetts Medical Society unless said bills have been submitted to your committee for approval or disapproval. A member may introduce a petition as an individual but it is unwise to permit him to state the position of

our Society at a hearing or elsewhere when neither the Council nor the Committee on State and National Legislation has given him authority to do so.

In brief our report is comparable to that of other years. We did not succeed in having any constructive legislation passed, but we have been able to prevent the passage of bills which would have lowered the present standard of practicing the healing art in Massachusetts.

WILLIAM H. ROBEY, *Chairman*,
THOMAS J. O'BRIEN,
FREDERICK E. JONES,
ARTHUR W. MARSH,
SHIELDS WARREN.

APPENDIX NO. 5

REPORT OF THE COMMITTEE ON MALPRACTICE DEFENCE

This Committee has been impressed by the fact that there has not been an increase in the number of cases brought to its attention during the past year as was expected, due to the financial condition of the times.

There have been only two new cases during the period from May 11, 1933 to May 18, 1934. There were ten cases pending up to May 11, 1933. One of these cases has been disposed of, leaving eleven cases pending at the present time. The case that was disposed of during the past year was one that was dismissed for lack of prosecution, under the rule, just as it was about to be reached for trial.

The Committee has not been informed of any unfair testimony in Court by any members of the Society during the past year.

FRANKLIN G. BALCH, *Chairman*,
EDWIN D. GARDNER,
FREDERICK B. SWEET,
ROYAL P. WATKINS,
ARTHUR W. ALLEN, *Secretary*.

APPENDIX NO. 6

REPORT OF THE COMMITTEE ON PERMANENT HOME

Our present plan of paying a proportionate rate of maintenance to the Boston Medical Library continues until September 30, 1936. The headquarters are being used much more frequently by members and by committees and the service rendered by the clerical force of the *New England Journal of Medicine* has been most satisfactory.

Your committee carefully considered the offer of a realtor concerning a certain estate on Beacon Street, Boston. While the price was satisfactory, the location of the property and the interior arrangement were not suitable for our needs as a permanent home. We voted unanimously not to accept it.

Our Building Fund has a book value of $52,679 and we hope to increase this total by future bequests and contributions.

THOMAS J. O'BRIEN, *Chairman*,
SAMUEL B. WOODWARD,
CHARLES G. MIXTER,
JOHN M. BIRNIE,
ROBERT B. GREENOUGH.

APPENDIX NO. 7

REPORT OF THE COMMITTEE ON POSTGRADUATE MEDICAL INSTRUCTION

The Committee on Postgraduate Instruction wishes to submit its first annual report. The program was begun a little over a year ago; the first course was started in Plymouth District on October 9, 1933; the last course to finish was Bristol North District on May 15, 1934. During this first teaching year all districts of the Society appointed chairmen on postgraduate instruction; without exception they have all functioned well. Much credit for the success of the courses is due to the unstinted interest and labor of these district chairmen.

In all, two hundred and thirty-two sessions were held in the various districts. These covered eighteen subjects. A faculty of one hundred and seventy instructors was organized; they went in teams of two or three. This method of teaching has been much appreciated by those who took the courses. Much credit and praise are due this group of devoted teachers who have given so generously of their time and effort to render a service which will have a lasting value to the Fellows of the Massachusetts Medical Society.

Although the Massachusetts Medical Society is not the first to start this type of extension teaching, our methods have attracted widespread interest. Already other state societies have written to the committee for information in regard to the plan of postgraduate instruction as sponsored by this Society.

On February 7, 1934 the district chairmen on postgraduate instruction held a meeting in Boston and voted unanimously to ask that the Council authorize the continuation of this work next year. At the present time the committee is preparing a new program which will be presented for the consideration of the Society in the near future.

A statistical summary of the past year's work follows:

Total number of postgraduate courses offered	22
Total number of postgraduate courses chosen	18
Total number of sessions	232
Number of district societies coöperating (100%)	18
Number of places where courses were given	24
Total registration for all courses	1002
Largest registration for one course	110
Smallest registration for one course	10
Total faculty	170

The Committee wishes to thank all officers and Fellows of the Society who have contributed to the success of this work. The Committee considers that the project of giving extension postgraduate instruction is very much worth while and recommends that a committee be appointed to arrange the program for the coming year.

FRANK R. OBER, *Chairman*,
LEROY E. PARKINS, *Secretary*.

APPENDIX NO. 8

REPORT OF THE COMMITTEE ON PUBLIC RELATIONS

I. Relative to hospital Plans A and B as designed for some nineteen hospitals in Metropolitan Boston, the Massachusetts Medical District Societies of Suffolk, Middlesex South and East and Norfolk have in substance, voted adversely to the acceptance of either plan. It may be that some time in the future, adequate discussion between the hospital executives and a representative Medical Commission formed by the Committee on Public Relations may result in a mutually satisfactory plan, as it is obvious that neither can exist and serve to the best advantage its several communities without the close coöperation of both parties.

II. On December 27, 1933 the Public Relations Committee met with the Secretary of the Claims Executive Committee of the Casualty Insurance Companies relative to the proposals made last May as presented to and approved by the Council of the Massachusetts Medical Society in June. He explained that the insurance companies could not take on added industrial expense as might be entailed by our recommendation No. 1, relative to admitting patients to hospitals as private patients—as they could not estimate the expense and they did not think anyone had figures that would be reliable. Furthermore he said that no one except the staff doctors would benefit. Finally it was unacceptable and the insurance companies preferred to carry on, as heretofore, without payment to the doctors for individual accident cases admitted to the wards for hospitalization. No. 2 in re consultations, the insurance companies made no objection and continued to indorse the proposition. No. 3 relative to the fairness of our charges—requires no comment. No. 4 concerns two weeks' treatment and the record sheet. The insurance companies are getting out a new uniform record sheet which they propose to use as a unit. No suggestion was offered for distribution or the availability of these in blank, and no proposal was made to alter the "present two weeks' treatment except in exceptional cases". No. 5 has to do with the recommendation of a board of three medical men to advise the Industrial Accident Board as to their findings in disputed cases. Here the insurance companies took no action—they would not support it, and neither would they contest it. They "leaned away from the recommendation, but would go along with the Board". No. 6—the Insurance Companies contend that the rules of evidence do not allow of an affidavit of the individual's physical condition and they therefore are antagonistic to the recommendation.

The end result of our conference was that, contrary to the opinion given to us, the insurance companies prefer to operate along legalistic lines rather than the coöperative methods outlined.

Meanwhile the Public Relations Subcommittee learned that in several communities industrial accident cases were automatically admitted to the hospitals as private or semi-private cases, as the individual was required to choose a physician for his care, signing a paper so indicating and then two witnesses affixing their signatures; so that the following letter and questionnaire were sent out to various hospitals throughout the State.

HOSPITALIZATION OF WORKMEN'S COMPENSATION CASES

The following recommendation of this committee was endorsed in June, 1933, at a meeting of the Council of the Massachusetts Medical Society.

> "As the employers have paid premiums for the care of the workingman's injuries, it is unreasonable to expect that doctors inside or outside of hospitals should take care of those cases without pay. We should ask that a patient sufficiently injured to need hospitalization should be recommended to a hospital as a *private patient*. We affirm that nurses and other agents should act only under the authority of the physician in charge of the case. Both the insurance companies and the doctors should be primarily interested in the early return of that patient to his work with as good a functional result as could be obtained. We believe that that principle is better business both for the insurance companies and the injured party, the hospitals and the attending doctor."

Your committee was aware that a number of hospitals in the state are now admitting industrial cases only to the semi-private rooms, thus allowing the attending physician to charge for his services. In order to find out how general this practice is, the following questionnaire was sent out to one hundred and twenty hospitals outside the city of Boston. Essentially the same inquiry was made by the Norfolk District Medical Society to twenty hospitals within Boston limits. Some hospitals, particularly in the Boston group, because of the nature of their work, have no occasion to admit industrial cases. Eighty per cent of the balance in both groups admitting industrial cases have returned the questionnaire, and the tabulated results are as follows:—

1) In your hospital, are industrial cases admitted as ward patients, in which case the attending physician receives no compensation?

	Yes	No	No Ans.
Hospitals in Boston	6	1	1
Hospitals outside Boston	13	71	0

Two hospitals in the Boston group answered "Yes and No". Seven out of the thirteen hospitals outside Boston answering "Yes" were located in Boston suburbs.

2) In your hospital, are industrial cases admitted only as private patients to the semi-private rooms, in which case the attending physician does receive compensation?

	Yes	No	No Ans.
Hospitals in Boston	4	4	2
Hospitals outside Boston	71	13	0

Eighteen out of the seventy-one hospitals outside Boston answering "Yes" admit industrial cases to the wards as private ward cases. Six of these eighteen are located in Boston suburbs.

3) Is your staff in favor of recommending to the trustees of your hospital that any injured patient, coming under the provisions of the Workmen's Compensation Act, shall be received on a private or semi-private base charge, shall be allowed to choose from the staff a physician who shall be responsible for his treatment and care, and who shall be eligible to make reasonable charges for his services?

	Yes	No	No Ans.
Hospitals in Boston	8	0	2
Hospitals outside Boston	69	2	13

4) Does your hospital have a "closed" staff?

	Yes	No	No Ans.
Hospitals in Boston	8	2	0
Hospitals outside Boston	40	41	3

5) Does your hospital have a "courtesy staff" which enables any reputable physician to treat industrial cases in the semi-private rooms?

	Yes	No	No Ans.
Hospitals in Boston	5	5	0
Hospitals outside Boston	67	16	1

6) If tightly "closed", would, in your opinion, your staff be willing to open its doors through a "courtesy staff" to any reputable physician who might desire to treat

an industrial case there in the semi-private rooms?

	Yes	No	No Ans.
Hospitals in Boston	4	4	2
Hospitals outside Boston	26	8	50

We recommend that all patients who come under the provision of the Workmen's Industrial Compensation Act on admission to a hospital be referred to private or semi-private rooms and that the patient be required to choose a physician who will be responsible for his care and treatment. The Secretary of the Massachusetts Medical Society shall inform by letter the trustees and staff of each hospital, admitting Industrial Accident cases to its facilities, of the action of the Council of the Massachusetts Medical Society.

III. In July, 1933 there was appointed by the Governor a board of five to inquire into the aspects of certain industrial diseases, e.g., silicosis and allied diseases in relation to tuberculosis. The Public Relations Committee was vitally interested in this matter because of the intention of the Legislative Act to enlarge the functions of the State Department of Health in establishing and training a personnel of diagnosticians, as an integral part of the Department of Health, who would examine and recommend the disposition of some 8650 men in industry, the number to be examined probably increasing as other fields were opened up. The Act provided in part as follows:

Section 5. Entrance Physical Examinations

That legislation be enacted to provide (a) that no person not previously so employed in the Commonwealth shall engage in any occupation in the granite or foundry industry in which there may be harmful exposure to dust unless his physical fitness so to do has been determined, within the twelve months next preceding, by the Department of Public Health by means of an examination, (b) that any person not prohibited by statute or regulation thereunder from engaging in such occupation and who has not been so examined within the twelve months next preceding shall be given opportunity to be so examined within thirty days after filing with the department a written application including a signed statement that it is his purpose to engage in such an occupation, (c) that the examinee shall be notified in writing, within ten days after such examination, whether or not he is found physically fit to engage in such an occupation, (d) that if an examinee found unfit files with the department within ten days after such notification a written appeal from the finding, it shall be reviewed by the Medical Board of Review provided for in the following recommendation numbered fourteen, which board shall hold a hearing if requested by the examinee and shall render to the department a decision which shall be final and of which notice shall be sent to the examinee as hereinbefore provided, (e) that no member or employee of the department or of the board, nor any of their records, shall be subject to subpoena in connection with the case of any person so examined, nor shall any such records be made public except at a hearing as hereinbefore provided, (f) that there shall be issued to each examinee found physically fit to engage in such occupation a certificate of fitness which shall bear the signature of the examinee and the date of the examination and shall be duly executed under the direction of the commissioner of public health, and (g) that no further examination of the lungs shall be necessary as a condition precedent to such employment of a person to whom a certificate of fitness has been issued within the twelve months next preceding.

Section 6. Annual Physical Examinations

That legislation be enacted to provide (a) that every person engaged in any occupation in the granite or foundry industry in which there may be harmful exposure to dust shall annually be examined by the Department of Public Health to determine his physical fitness to continue in any such occupation, (b) that no finding of such physical unfitness shall be made except on evidence of active pulmonary tuberculosis, (c) that every examinee found unfit so to continue shall be so notified in writing, (d) that if an examinee found unfit files with the above department within ten days after such notification a written appeal from the finding, it shall be reviewed by the Medical Board of Review provided for in the following recommendation numbered fourteen, which board shall hold a hearing if requested by the examinee and shall render to the above department a decision which shall be final, (e) that, if the decision is contrary to the finding reviewed, the examinee shall be so notified in writing, (f) that, if the decision confirms the finding reviewed, or if an examinee found unfit fails to appeal as hereinabove provided, the Department of Public Health shall in writing notify the Department of Industrial Accidents and the Department of Labor and Industries that the examinee has been found physically unfit to continue in any occupation as hereinbefore described and the last-named department shall so notify the examinee and his employer, if any, (g) that an examinee so found unfit may apply, not less than twelve months after such finding, for a reëxamination in accordance with provisions (b), (c), (d), (e) and (f) of the recommendation next preceding, any certificate of fitness issued in such case to bear the word "readmitted", (h) that any person who, having received notice of physical unfitness from the Department of Labor and Industries as hereinbefore provided, continues in any occupation for more than thirty days in contravention thereto or returns to such occupation except after readmission as hereinbefore provided, shall forfeit all rights to compensation for disability due to pulmonary disease under the Workmen's Compensation Act, (i) that no member or employee of the Department of Public Health or of the Medical Board of Review, nor any of their records, shall be subject to subpoena in connection with the case of any person examined as hereinbefore provided, nor shall any such records be made public except at a hearing as hereinbefore provided, (j) that the Division of Tuberculosis of the Department of Public Health shall give special preference in the extension of its facilities to persons who, deprived of employment because of a finding of unfitness as hereinbefore provided, have been resident in the Commonwealth on the effective date of this legislation or for one year prior to the date of such finding, (k) that the Division of Public Employment Offices of the Department of Labor and Industries shall give special preference in the extension of its facilities to the dependents of such persons, (l) that the Division of Public Employment Offices of the Department of Labor and Industries and the Division of Rehabilitation of the Department of Education shall give special preference in the extension of their facilities to such persons if subsequently restored to fitness for employment, (m) that every person who, having been deprived

of employment because of a finding of unfitness as hereinbefore provided and being in need of relief or assistance, has been a citizen of the Commonwealth on the effective date of this legislation or for one year prior to the date of such finding shall, on having received compensation for disability due to pulmonary disease in the full statutory amount, or at once if ineligible for such compensation, be entitled to assistance as provided for by Chapter 118A of the General Laws, as amended, irrespective of any provision thereof contrary hereto, for as long as such need and unfitness continue, and (n) that the official or body providing such assistance may at any time require that any such person be reëxamined, as hereinbefore provided, in order to determine whether or not the unfitness continues.

Section 13. Occupational Medical Staff

That legislation be enacted to provide that there be added to the personnel of the Division of Adult Hygiene of the Department of Public Health a medical staff and such assistants and facilities as may be necessary to the efficient performance of their duties, which shall be (a) to investigate and report to the Industrial Accident Board on the medical aspects of all cases coming before the board for compensation for silicosis, asbestosis or pulmonary tuberculosis and to so investigate and report in such cases coming before the board for *other occupational diseases as the board may refer to them*, their reports and findings to be admissable as evidence before the board or any member thereof, but no member or employee of the department to be subject to subpoena in connection therewith, (b) in any fatal case coming before them, to order an autopsy if in their opinion it is advisable for the purpose of determining a fact material to any party at interest, (c) to make such findings of physical fitness as are provided for in the preceding recommendations numbered five and six, (d) to study the effects upon health of materials and processes used in industry, in connection with which studies no member or employee of the department shall be subject to subpoena, and (e) in coöperation with the Department of Labor and Industries, to promote occupational health education.

The question was brought before the New England Roentgen Ray Society and the Tuberculosis Section of the Massachusetts Medical Society. The following resolution relative to the matter was passed by the New England Roentgen Ray Society.

March 16, 1934.

Be it resolved that the New England Roentgen Ray Society, in meeting assembled, by a unanimous vote strongly disapproves of Sections five, six and thirteen of the recommendations of the State Department of Public Health for legislation regarding the appointment of a special Industrial Disease Commission for the following reasons:

1. That although yearly examinations of employees in industry may be desirable, it is not within the province of the Department of Public Health to spend funds for the protection of private injury.

2. That the present provisions of the Workmen's Compensation Act for the employment of impartial physicians make such legislation unnecessary.

3. That the proposed plan of placing the study of these cases in the hands of men inexperienced in roentgenology, and equipped with inadequate apparatus is unsound; especially when there are men of broad experience with adequate apparatus available.

A committee appointed by the President of the Massachusetts Medical Society was unanimous in condemning the section of the Act designed to allow the establishment of this clinical board though wholly sympathetic with the ideas of preventive medicine incorporated in the bill. We hope that if further revision of the bill seems advisable, that adequate representatives of the Massachusetts Medical Society may be added to the board as originally appointed, believing that less drastic measures, educational to industry, may lead to the desired result.

We recommend that the Massachusetts Medical Society through its President actively concern itself in medical appointments and activities outside of legislative matters at the State House.

IV. A meeting was held in April of the Public Relations Subcommittee with two members of the Public Health Council and the Commissioner of Public Health which was largely devoted to a discussion of present and future policies of the State Department of Health. Insistent and cordial encouragement was given to the Commissioner to call upon the Massachusetts Medical Society through its President for discussion and coöperation of its program as it develops, dependent on the state of public health. We had been disturbed by newspaper reports and other sources of information of proposed enlargement of the State functions relating to the care of Chronic Heart Disease and Arthritis. We are definitely assured that the Department of Public Health does not wish for such added burdens and that the Cancer Control program was enacted by legislation contrary to its desires. We are deeply appreciative of the excellence of the work done under the direction of the State in its Cancer program but we believe that this should have been inaugurated by the Massachusetts Medical Society and future programs for the alleviation and care of chronic diseases should be initiated and controlled through agencies of the Massachusetts Medical Society.

We deprecate the attitude of certain interests that, without forwarding specific education of the medical profession in so far as the present understanding of the disease process permits, are already agitating for state hospitalization and care of individuals so afflicted with arthritis as to need medical attention. We urge the medical profession's organized opposition to any plan that would provide facilities for terminal hospitalization in such cases. Such a program presumes that medical knowledge is static and would enormously increase the burden of taxation both upon the public and the medical profession, which is concerned with the care of the sick.

V. In the matter of Federal Compensation practices, the Public Relations Committee sent a telegram January 2, 1934 to the President of the United States, and other officers of the Government, as printed in the *New England Journal of Medicine* of January 11, 1934.

"An Urgent Protest Adopted at a Meeting of the Committee on Public Relations Held in Boston, January 2, 1934. Whereas, the Civil Works Administrator of the United States, Harry L. Hopkins, has instructed John J. Morris, Counsel for the Civil Works Adminstration of Massachusetts, to place all employees injured in the Civil Works program under the Federal Compensation Act and

"Whereas, this procedure is antagonistic to the Massachusetts Law for workmen's compensation in so far as it deprives the injured workman of the right to select his own physician,

"Be it resolved that the Massachusetts Medical Society, composed of four thousand and nine hundred Massachusetts physicians, acting through the Committee on Public Relations, protests the application of the Federal Compensation Act to the Civil Works program in Massachusetts and

"Be it further resolved that we respectfully urge that the man injured in Civil Works program has the right to select his own physician."

In answer to this, we have under date of January 15, the following reply:

"FEDERAL CIVIL WORKS ADMINISTRATION,
1734 NEW YORK AVENUE, WASHINGTON

January 15, 1934.

"Thank you for sending us copy of telegram from the Massachusetts Medical Society.

"The United States Employees' Compensation Commission is administering the compensation provisions for Civil Works Administration employees. However, the Commission has informed our State Administrators that the bulletin on medical facilities, which shows the physicians designated to treat injuries, is of long standing and was not issued for Civil Works purposes but for the treatment of Civil employees of the United States; that for Civil Works purposes it was not intended to exclude other reputable physicians willing to give treatment at reasonable rates in accordance with Rules and Regulations No. 5, and that local administrators are authorized to advise the local medical profession and organizations accordingly and to make arrangements to permit such physicians to participate in rendering this service on the basis indicated.

Very truly yours,

BRUCE MCCLURE, *Secretary*,
Federal Civil Works Administration."

However, we are informed by the President of the Massachusetts Medical Society that he is unable to find at the present time, January to June, that any funds are available for the payment to physicians in civil practice who may have been called to attend such cases.

The following recommendation was adopted by the Council at its meeting in February, 1934 and is inserted here as a matter of record.

> The Committee recommends that it be authorized by the Council to represent the Society's interests in dealing with Federal Emergency Relief Administration, Civil Works Administration and such other economic measures as may from time to time arise. We further recommend that a committee be established by each district society to act as liaison with local governmental officials and through the Public Relations Committee of the State Society with the State administration. This will establish machinery in Massachusetts in accordance with federal recommendations in Bulletin 7 F. E. R. A. and as is well exemplified by the New Jersey State and local societies (reported in the *A. M. A. Bulletin* for October). Free exchange between local and state committees of information on policies and actions is highly desirable.

VII. COSTS OF MEDICAL CARE

Since the publication of the report on the Costs of Medical Care, there has been so drastic a change in economic conditions that many of the factors upon which the Committee based its findings are not applicable today. Interest has been aroused both within and without the medical profession, however, and we recommend that doctors in their several communities forward a movement for the more efficient control of disability and disease. The problem will vary in the different parts of the State and probably in different cities and may be met in part by the following suggestions:

1) Availability of hospital beds for the use of the practitioner not on the visiting staff of the hospital. (Tends to education and better standing of the local practitioner with consequent better care of his patients.) It is probable that in teaching hospitals there would be less possibility of this procedure than in institutions not primarily devoted to teaching.

2) Group practice, e.g., Hanover, New Hampshire plan. (May be varied according to local conditions.)

3) Closer coöperation of the local and State Boards of Health with the medical profession. In any health measure, the local doctors are as much interested as anyone, probably more so. This is also highly applicable to the State Board of Health tuberculosis program.

4) Rigid scrutiny of the patient applying for free treatment at a hospital. (The efficient care of the indigent sick in the communities obviates the menace of State Medicine.) Statistics seem to indicate that from one to seven per cent abuse the privilege of hospitals for the care of indigent patients and it may be that because of our refinements in medical practice obtainable at the hospitals in contradistinction to general practice, that this demand is made by both the poor and the well-to-do. Bearing on this are certain resolutions to be introduced on the floor by the Norfolk District Medical Society which we heartily endorse in principle and commend to the favorable consideration of every Councilor present.

5) Adequate representation of Doctors of Medicine on hospital boards. In no other profession is it apparent that their activities are so largely directed by extraneous even though perhaps sympathetic agencies.

6) Entrance of the doctor into public life. With his educational and social background, greater opportunities for the people he represents await his willingness to take this step. Medical practice is undergoing a process of evolution and, if we can do so without entering upon a period of dangerous experimentation either upon ourselves or our patients, it behooves us to meet changing conditions with changing methods, learning what to avoid by the unfortunate English panel and German governmental systems, and by contact with other sections of the Country, inaugurate those principles proved to be acceptable and successful.

In all of the above suggestions, much might be said in elaboration of the ideas which we believe may be left to the imagination of those interested; but more

important than any one of them is the basic idea of inducing closer coöperation and contacts of neighboring practitioners. No one can do that for them and if they are unwilling to take so short a step, then we may expect them to wander farther in the wilderness.

In all of our work we should be concerned with the preservation of the precious traditions that have been ours through many previous decades and in the evolution and advance of the practice of medicine be solicitous that doctors should take the lead.

The Costs of Medical Care has had the earnest consideration of doctors, philanthropic and economic agencies throughout the Commonwealth and we are inclined to urge that the community interests should solve the individual questions, thus achieving better personal results from the viewpoint of the patient and the doctor. Cities and towns are slow to believe that money spent for health and sanitation is either necessary or economically sound and we advise that doctors in their several communities become active participants in this campaign of education. Thus practitioners coöperating with each other and with local boards of health may attain results for the residents of a community through already existent facilities, or by such additions of personnel or buildings as may be determined to be necessary after sufficient study has been made, to insure adequate solution of the problems presented. This means at least local public interest on the part of the medical profession in each city and town, and, with one or more doctors willing to undertake this responsibility, we believe that the greatest service for the public and the medical profession would follow. The public health officer should be encouraged to call upon the local physicians for suggestions and coöperation, as poor sanitation and inefficient control of communicable disease mean "poor medicine" and the public should be taught and is willing to look to the medical profession for its welfare under all conditions.

WILLIAM H. ROBEY, *Chairman*,
Committee on Public Relations;
ELMER S. BAGNALL,
J. HARPER BLAISDELL,
WILLIAM G. CURTIS,
FRED R. DAME,
FRANCIS H. DUNBAR,
HARRY W. GOODALL,
ERNEST L. HUNT,
WALTER A. LANE,
WILLIAM F. MACKNIGHT,
THOMAS H. MCCARTHY,
RICHARD A. MCGILLICUDDY,
CHARLES E. MONGAN,
*FRANCIS E. O'BRIEN,
P. J. SULLIVAN,
MICHAEL A. TIGHE,
JOHN I. B. VAIL,
HARPER E. WHITAKER.

*Not present when report was adopted.

APPENDIX NO. 9

OFFICIAL COPY OF ACCEPTED RESOLUTIONS OF THE RESOLUTIONS COMMITTEE OF THE NORFOLK DISTRICT MEDICAL SOCIETY

Whereas free and nearly free treatment privileges in municipal and endowed charitable hospitals are designed primarily for the indigent and when properly managed meet with the approval, coöperation and support of the medical profession, and

Whereas the growing extension, in such institutions, of this care and treatment to the non-indigent results in a lessened efficiency and a comparative neglect of the deserving people for whom these privileges are established, and

Whereas this recognized abuse of such medical charity often results in unwitting and unfair competition with the private physician by these supposedly charitable institutions, therefore

Be it resolved that:

1. The Norfolk District Medical Society through its Councilors urge upon the Massachusetts Medical Society the need for immediate corrective action to speedily bring relief from the aforesaid existent conditions through appropriate legislation and all other necessary measures.

2. The Norfolk District Medical Society through its proper officers and committees bring the matter at once to the attention of His Honor, the Mayor of the City of Boston, and to the proper authorities of the various charitable hospitals in Greater Boston, urging that these cited abuses and impositions be discountenanced and that every effort be made to correct and eradicate them.

3. There be established in Boston by the municipality or by the coöperation of private agencies representative of the charitable hospitals, or both, a duly accredited agency or clearing house which shall investigate the financial status of all applicants for medical charity, in any and all branches, and which shall be empowered to issue suitable and certified credentials to those found worthy of gratuitous treatment.

4. Pending the establishment of this proposed agency or clearing house. each institution in question be urged to make every effort to expedite the correction of these existing abuses by the signed statement of each applicant in affirmation of the necessity for gratuitous treatment; further, to display in such a manner as to be easily read by all applicants for charitable aid, in any and all branches, a suitable sign indicating clearly that the institution, or at least that particular department, is for charity patients only and is not open to those financially able to pay a fee to a physician, and finally, should it be learned at any time that this entrance requirement has been ignored by any applicant, a penalty of the immediate termination of treatment shall be exacted.

5. Copies of this resolution be placed in the hands of neighboring district societies with the request that such societies join with the Norfolk District Medical Society in this movement to correct and eradicate the aforesaid abuses of medical charity.

Signed:
FREDERICK L. HAYES, *Chairman*,
MAURICE GERSTEIN,
DAVID L. HALBERSLEBEN.

April 18, 1934.

TREATMENT OF HYDROCEPHALUS BY ENDOSCOPIC COAGULATION OF THE CHOROID PLEXUS*

Description of a New Instrument and Preliminary Report of Results

BY TRACY J. PUTNAM, M.D.†

HYDROCEPHALUS of the communicating type has been so long recognized as a progressive and usually fatal disease that many attempts have been made to devise methods of relieving the condition by operation. The history of the subject has been ably reviewed by Davidoff[1] and we see from his paper that although many of the suggested operative procedures are extremely ingenious, and occasional good results have been reported, none of them have become widely accepted. Dandy[2] as a result of considerable experience regards third ventriculostomy as the method of choice. The operation which has apparently yielded the best results at this hospital is that at first advocated, but later abandoned by Dandy[2], namely, removal of the choroid plexuses of both lateral ventricles by open operation. While no extensive statistics have been reported, some patients are still alive months after the operation, without progression of symptoms. Judging, however, from the experiences of neurological surgeons in this community (including my own) the operative mortality is high. Even when life is prolonged, the end results are apt to be disappointing, for the manipulation involved in emptying the ventricle and retracting its walls to expose the plexus almost inevitably leads to extensive cortical damage.

Believing that the principle of Dandy's operation is physiologically sound, it occurred to me that it might be carried out by an endoscopic procedure. Dr. W. Jason Mixter showed many years ago that it is perfectly feasible to examine a hydrocephalic ventricle by means of an urethroscope[3], and was kind enough to place his instrument at my disposal. But this, and all the other endoscopic devices ordinarily available proved to have certain disadvantages (such as focal length of lens system, inadequate field, bulk, etc.) which rendered them unsuitable for the purpose. Experience with microscopy of the choroid in animals[4] showed that actual contact of the instrument with the plexus was essential for accurate vision in a cloudy medium. The necessities of a device to employ the coagulating currents of a modern diathermy generator made the use of a metal sheath disadvantageous. Finally, actual experience at the operating table dictated the shape and dimensions of the completed apparatus*.

The coagulating ventriculoscope (figs. 1 and 2) in its present state consists of a rod of optical glass with polished ends. The ventricular end is plane, while the observer's end is ground with a slight curve of which the focal length is approximately equal to the length of the instrument. The rod bears a deep longitudinal groove in which lies a tiny bronchoscope light and its carrier. Two other smaller grooves carry the electrodes for diathermy, which are cemented to the glass and covered by an insulating enamel. The tips of the electrodes are bare, and are bent slightly toward each other so that they appear in the field of vision. The instrument is sterilized by immersion in alcohol, and is encased in a tube of rubber dam when in use. The ventriculoscope is made in two sizes, one ten centimeters long and six millimeters in diameter, the other eighteen centimeters long and seven millimeters in diameter.

The actual operation is carried out on one side at a time, usually under avertin anesthesia. Ether should be avoided. A longitudinal incision is made through the scalp about three centimeters from the midline, in the parieto-occipital region. The bone is drilled and rongeured away over an area about four centimeters in diameter. The dura and then the pia are incised and clipped together to control bleeding and prevent collapse of the cortex. The handle of a scalpel is thrust through the white matter, and followed by the tip of the ventriculoscope. The room is then darkened, and the operator puts on a sterile celluloid mask.

By careful maneuvering, it is possible to follow the small veins on the walls of the ventricle down to the fossa in which the plexus lies. The plexus itself is a flocculent copper-red structure, floating free in the fluid. When the ventriculoscope is pressed against it and the coagulating current turned on, sparks surround the electrodes and the tissue within the field turns white. Bit by bit most of the choroid in the body of the ventricle may be destroyed. In some instances there is a defect in the septum pellucidum, and the contralateral plexus may also be attacked.

Coagulation usually lasts five to twenty minutes. The patient often moans slightly when

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*I must acknowledge my indebtedness to Mr. Walter G. Wolfe of Pinkham and Smith Co., Boston, for his expert assistance with the optical system.

the current is turned on. The instrument is finally withdrawn, and the wound carefully sutured. The reaction to the operation is slight, and directly proportional to the amount of hemorrhage. Often the infant will be able to take its feedings the same afternoon. In some instances, there has been no perceptible change in the clinical chart to mark the day of operation.

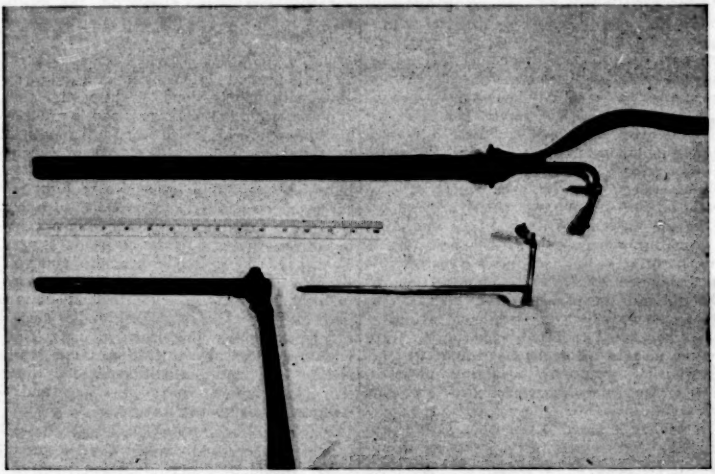

FIG. 1. The two models of the coagulating ventriculoscope. The larger model is shown assembled, with light-carrier in place. The lamp and carrier are shown separated from the smaller model. The heavy wires attached to the observer's end of both instruments are for the coagulating current.

Endoscopy with coagulation has been carried out twelve times in seven unselected cases of hydrocephalus—all those brought to the Surgical Service for treatment within the last five months. The infants varied in age from one to eighteen months at time of operation. In most of the cases, hydrocephalus had come on following operations for meningocele. In an additional case, the choroid was coagulated to relieve the pressure within a meningocele although the head was not enlarged at the time, and the results appear to justify the step.

FIG. 2. Enlarged view of the ventricular end of the larger instrument, to show the electrodes.

Two of the children in the series have died, but it seems fair to question whether either death should be ascribed to the operation. The first case was that of a mentally retarded girl of four months, whose head had grown to the size of thirty-one centimeters following an operation for meningocele. The choroid was coagulated on the right, and a week later on the left. The child was doing satisfactorily after the second operation and the head had decreased to a diameter of twenty-nine centimeters, when the family became uncooperative and insisted on taking her home. She died of a respiratory infection about a week later.

The second fatal case was that of an apparently bright male infant of about a month, whose head measured forty-five centimeters in diameter, and was growing progressively. The fontanelle was tense. Coagulation of the choroid was carried out on one side with little immediate reaction, and the baby did well for two days, but then developed diarrhea and died a week after operation.

Of the six remaining patients three who have survived the operation for seventeen (fig. 3), five and four weeks respectively, appear to be definitely relieved at present. Their heads have remained stationary or decreased in size, and the fontanelles have become sunken. The pressure has been definitely decreased in two other cases still in the hospital, but it is too early to be

sure that the condition is arrested. The sixth child, an intelligent girl of fifteen months, had a head which measured seventy-three centimeters before the second operation, and sixty-seven centimeters three weeks later. At present, seven weeks from operation, there appears to be an obstruction of the aqueduct, doubtless from a clot, which will probably require further attention.

It is difficult to judge accurately of an infant's mental capacity, but at least four of the patients in the present series appeared normally active and bright. Two of those with the largest heads appeared alert and intelligent. The procedure had no apparent effect on mentality in any of the cases. Two patients had a few convulsions in the first two weeks postoperative. No other abnormal neurological manifestations ascribable to the operation have been made out.

Considering the otherwise almost hopeless outlook for the disease, the immediate results appear encouraging. It remains, of course, to be seen what the final outcome will be, but it seems reasonable to suppose that it should be at least as good as that of the cases in which the choroid has been removed by open operation, in some of which it appears that permanent relief has been obtained.

SUMMARY

1. A new endoscopic instrument is presented with which it is possible to destroy the choroid plexuses within the lateral ventricles by means of electrical coagulation without removal of spinal fluid.

2. The procedure has been used in seven cases of communicating hydrocephalus in infants and one of meningocele without hydrocephalus with encouraging results so far. Bulging of the fontanelles has been relieved and the diameter of the head has been decreased in all cases except one.

3. There have been two deaths in the series, both due to intercurrent diseases, and possibly not to be attributed to the operation. The intracranial pressure was relieved up to the time of death in these cases also.

FIG. 3. R. W., aged four weeks at time of first operation (left) and two months later (right) to show collapse of the fontanelle following coagulation of the choroids.

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See next page for further illustrations

These illustrations complete the article on "Treatment of Hydrocephalus" by Dr. Putnam

FIG. 4. A. M., fifteen months old, who developed hydrocephalus following operation for meningocele. Before coagulation of choroids.

FIG. 5. A. M., four weeks after coagulation of both choroids through a single incision. Notice depression of fontanelle.

ACUTE PANCREATIC NECROSIS IN ACUTE AND CHRONIC ALCOHOLISM*

BY WALTER K. MYERS, M.D.,† AND CHESTER S. KEEFER, M.D.†

EVERYONE who has had an opportunity to study a group of cases of acute pancreatic necrosis has commented upon the fact that alcoholism is a predisposing factor. A few clinicians have observed cases of pancreatic necrosis following bouts of acute alcoholism, but its occurrence under these circumstances is not generally appreciated. We have recently observed

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such a case. For this reason the records have been analyzed of twenty-nine cases of pancreatic necrosis, twenty-two cases of chronic pancreatitis, and twenty-four cases of focal fat necrosis of the pancreas which have been observed in the Pathological Laboratory of the Boston City Hospital, in order to gather more information regarding the factors associated with these conditions. Especial attention has been directed to the occurrence of these conditions in association with acute and chronic alcoholism.

TABLE 1

CONDITIONS ASSOCIATED WITH ACUTE AND CHRONIC LESIONS OF THE PANCREAS

	Acute Pancreatic Necrosis	Chronic Pancreatitis	Focal Fat Necrosis
Cirrhosis of Liver	2	5	7
Fatty Liver	4	1	1
Acute and Chronic Alcoholism	6	1	1
Obstruction or Infection of Bile Ducts	5	5	5
Cholelithiasis	5	2	3
Carcinoma of Common Duct	0	2	1
Empyema of Gall Bladder	0	1	1
Miscellaneous	13	10	10
Cause Obscure	9 (? Alcoholism 3)	8	3
Pregnancy	1	—	—
Extension Ulcer of Stomach and Duodenum	2	—	1
Tuberculosis	—	—	2
Diabetic Coma	—	—	1
Cardiac Insufficiency with Congestion	1	2	3

The results of the study of these records are summarized in table 1. The distribution of the associated conditions was similar in all three groups; that is to say, these pancreatic lesions were found to occur in patients with alcoholism or diseases commonly associated with chronic alcoholism in approximately one-third of the cases. Indeed, of the nine cases of pancreatic necrosis in which the cause was obscure, it is probable that three additional cases were associated with alcoholism. Of the cases of chronic pancreatitis, in which the predisposing factors were undetermined, a few were associated with obesity or arteriosclerosis. In some the history concerning drinking habits was inadequate so that it is impossible to say whether any of these cases might have resulted from alcoholism.

Abstracts of the records of the six cases of pancreatic necrosis following alcoholism are briefly given.

REPORT OF CASES

CASE 1. A young man, thirty years of age, was admitted to the hospital complaining of abdominal pain and vomiting of one week's duration. For about fourteen months prior to admission he had been drinking very heavily, and frequently drank as much as a quart of "alky splits" a day. Twelve months before entry, he had an attack of nausea and vomiting which lasted for six days. On numerous occasions following an alcoholic spree he would have intermittent abdominal pain and vomiting.

Six days before admission to the hospital, following a bout of drinking he was seized with severe epigastric pain and vomiting. The pain was constant and accompanied by four or five attacks of vomiting a day and obstipation. He had felt hot and flushed and had been in bed for three days before admission.

Upon examination, the patient appeared acutely ill. He was mentally clear and alert and complained only of abdominal pain. The temperature was 104°F., the pulse rate 160 per minute, and the respirations were 26 per minute. The face and extremities were cyanotic with a yellowish tinge. The heart rate was rapid but the sounds were clear. The lungs showed nothing abnormal. The abdomen was distended but everywhere tympanitic without evidence of free fluid. There was tenderness and some rigidity of the abdomen above the umbilicus and some pain and tenderness in the left flank. A friction rub was heard over the liver below the rib margin on the right side and normal peristaltic sounds could be heard with the stethoscope.

The white blood count was 15,100 per cubic millimeter with 87 per cent polymorphonuclear cells; the icteric index was 100 units and the non-protein nitrogen of the blood was 40 mg. per cent.

A laparotomy was decided upon and a typical hemorrhagic pancreatitis was found. There was no evidence of obstruction in the bile ducts. The capsule of the pancreas was drained. The patient died one hour after the operation. There was no autopsy.

CASE 2. A white man, aged forty-three years, who had drunk alcohol to excess was admitted to the hospital on account of abdominal pain, fever and jaundice. He had had two similar attacks during the past two years. The onset of the illness had been abrupt with abdominal pain, nausea and vomiting. Upon examination, there was icterus, tenderness in the epigastrium and a palpable mass beneath the liver. The temperature varied from 100°F. to 102°F., and the jaundice persisted. Three weeks after the onset the patient was operated upon; an abscess under the liver was incised and drained. The pus contained B. coli. Following the drainage of the abscess, the edges of the wound showed evidences of digestion. The patient failed gradually and died one month after the onset of the acute symptoms.

Anatomical Diagnosis: Suppurative pancreatitis. Localized peritonitis. Retroperitoneal abscesses about the tail of the pancreas. Thrombosis of splenic artery. Infarcts of spleen. Jaundice. Obesity. No evidence of cholelithiasis.

CASE 3. A white woman, twenty-seven years of age, drank daily large quantities of whiskey for three weeks prior to admission. This was followed by severe nausea and vomiting of several days' duration; then there appeared severe pain in the abdomen, especially over the left hypochondrium. The size of the abdomen was increased. Examination revealed an obese woman, with rapid, thready pulse, cold clammy skin, no elevation in temperature and a large firm tumor filling the whole left side of the abdomen. There was tenderness over the tumor. At

operation, this mass was covered with omentum and extended from the brim of the pelvis upward behind the stomach where it was adherent to the posterior wall; it contained serosanguineous fluid which was evacuated. Drains were inserted. After operation the patient developed the signs of fluid in the left pleural cavity and died six days later.

Anatomical Diagnoses: Pancreatitis with cyst formation. Acute fibrinous peritonitis. Pleurisy with effusion (left). Early serofibrinous pericarditis.

CASE 4. A white man, thirty-three years of age, acknowledged excessive drinking for a period of ten years. Recently he had taken little food and had developed the symptoms and signs of multiple neuritis with pains in the arms and legs. For several days before admission he had had persistent nausea and vomiting without abdominal pain. Upon examination there were the signs of peripheral neuritis, and marked oral sepsis. The abdomen was soft and no masses or tenderness were made out. He continued to vomit for three days but there was no essential change in his general condition until the day of his death. Suddenly he complained of extreme weakness and developed the signs of collapse with a tachycardia, cold extremities, sweating and dusky cyanosis. Death followed shortly after the appearance of these symptoms.

Anatomical Diagnoses: Pancreatic necrosis with peripancreatic, perinephric and retroperitoneal hemorrhage on the left side. Fatty liver.

CASE 5. A woman, aged forty-two years, who had drunk four to five glasses of beer and about one pint of whiskey a day for several years, was admitted to the hospital. For one month before admission she had been drinking more than usual. Three days prior to entry she began to vomit almost constantly and the abdomen became distended and tender. Upon examination she was found to be prostrated; the temperature was 100°F.; the pulse rate was 100 per minute; and the heart sounds were distant. The abdomen was distended, and there was tenderness in the epigastrium. The white blood count was 14,000 per cubic millimeter. For five days she remained in about the same condition with the temperature varying from 98°F. to 101°F. She then failed rapidly and died.

Anatomical Diagnoses: Cirrhosis of the liver with fatty changes. Sclerosis of the pancreas with multiple areas of acute fat necrosis. Edema of the brain.

CASE 6. A young man, aged thirty years, had been drinking to excess for three months. Ten days before entry he was seized with severe abdominal pain, vomiting and pain in the back. He was restless and delirious, the abdomen was distended and there was tenderness across the epigastrium with extreme pain upon pressure. The temperature was 99°F. The leucocyte count was 24,000 per cubic millimeter. At operation the omentum was found to be thickened and contained many areas of fat necrosis; the pancreas was enlarged and indurated. The gall bladder was distended but appeared normal. Death occurred six hours after admission.

Anatomical Diagnoses: Acute hemorrhagic pancreatitis with fat necrosis. Fatty liver.

From these cases, there is no doubt that acute pancreatic necrosis is occasionally seen following acute alcoholism when there are no other demonstrable factors to account for it.

Similar instances of acute pancreatic necrosis following acute alcoholism have been noted by McWhorter[1], Scheel[2], Mondon[3], and Émile and André[4].

Mondon reported a case of a young man who was admitted to the hospital with alcoholism, vomiting and tachycardia. The necropsy showed a hemorrhagic pancreatitis with hemorrhagic infiltration of the stomach, duodenum and upper jejunum, and thrombosis of the terminal branches of the superior mesenteric vein and the coronary veins of the stomach. The interpretation of the sequence of events in this case was not clear. Of the cases described by Émile and André all five were diagnosed cardiac insufficiency. Three were admitted with the diagnosis of acute alcoholism, one with the diagnosis of chronic alcoholism, and in the fifth the history was obscure. Necropsy showed that death resulted from pancreatic necrosis.

Aside from the cases of acute pancreatic necrosis following acute and chronic alcoholism, chronic lesions in the pancreas are not uncommon in patients who have used large quantities of alcohol during life. Gross and Guleke[5] discuss at length the rôle of chronic alcoholism as a cause of pancreatitis, especially the chronic forms of the disorder. They are of the opinion from their own experiences and from a study of the literature that patients with chronic alcoholism commonly show anatomical alterations in the pancreas. These lesions are described as an increase in the intra- and inter-lobular fibrous tissue. We were able to confirm this opinion.

Not uncommonly, in patients who eventually show the lesions of chronic pancreatitis, there is a history of previous attacks of upper abdominal pain. These attacks of pain, if any diagnosis was made, may have been called acute gastritis. On the contrary, in the cases in which fat necroses are found, the symptoms during life may not lead to a suspicion of pancreatic disease.

The mechanism whereby pancreatic necrosis follows alcoholism is not evident. Three possibilities are suggested: the effect of alcohol on the pancreas as it is carried to it by the blood stream, obstruction or infection of the pancreatic ducts due to duodenal congestion following acute alcoholism and the forcing of duodenal contents or bile into the pancreatic ducts as a result of persistent vomiting.

Objections to all three of these possibilities may be raised. It is probable that no one cause will be found. Chronic changes do occur in the pancreas in the absence of duodenal congestion or infection. If it is admitted that alcohol plays a rôle in the production of changes in the liver, it would be difficult to deny the possibility of similar processes taking place in the pancreas. The question of the regurgitation of duodenal contents into the pancreatic ducts during the act of vomiting is one which has excited controversies. Some physicians[6] doubt that it is possible to force duodenal contents into the pancreatic ducts by increased intra-ab-

dominal pressure, as occurs with vomiting and retching. Others have reported cases of pancreatic necrosis following vomiting and retching as a result of general ether anesthesia[7, 8]. It is possible that the development of acute pancreatic necrosis following vomiting will depend to some extent upon the exact anatomical relationship of the opening of the pancreatic ducts into the duodenum. That is, pancreatic necrosis may follow vomiting and retching if the pancreatic ducts open directly into the duodenum. These questions must remain unanswered for the present.

THE DIAGNOSIS OF PANCREATIC NECROSIS

The diagnosis of pancreatic necrosis is made from an appreciation of the predisposing factors, a knowledge of the clinical features, the recognition of the complications, and the consideration of the diseases with which it may be confused.

In table 2 have been included a great many conditions in which pancreatic necrosis may occur. Some are rare. In others the pancreatic process is but a part of the primary condition. However, a full appreciation of the etiologic or predisposing factors is essential in arriving at a correct diagnosis.

TABLE 2

ETIOLOGY OF ACUTE PANCREATIC NECROSIS

I. *Obstruction or Infection of the Biliary Passages.*
   1. Stones in Bile Ducts.
   2. Infections of Bile Ducts.
   3. Tumors of Bile Ducts.
   4. Duodenal Diverticula.
   5. Parasites—Ascaris Lumbricoides.

II. *Acute or Chronic Alcoholism.*
   1. Fatty or Cirrhotic Liver.
   2. Following Vomiting and Retching.

III. *Extension of Infections to Pancreas.*
   1. Perforated Gastric Ulcer.
   2. Empyema of Gall Bladder.
   3. Perinephric Abscess.

IV. *Trauma—Surgical.*
   1. Nephrectomy.
   2. Cholecystectomy with Common Duct Drainage.
   3. Splenectomy.
   4. Resection of Stomach or Duodenum.
   5. Retrograde Embolism of Omental Veins.

V. *Circulatory Disturbances—Local and General.*
   1. Local.
      (a). Embolism of Pancreatic Artery.
      (b). Retrograde Embolism from Omental Veins.
      (c). Postoperative Thrombosis of Intrapancreatic Veins.
   2. General.
      (a). Cardiac Insufficiency with Congestion.

VI. *Acute Infections.*
   1. Epidemic Parotitis.
   2. Typhoid Fever.

VII. *Miscellaneous Conditions.*
   1. Poisons—Lysol—Oxalic Acid.
   2. Food Poisoning.
   3. Following Anesthesia.

Attempts are made to divide acute pancreatitis into various types: hemorrhagic, gangrenous, and suppurative. From a study of any group of cases it seems apparent that in each one there is essentially the same process. Such a classification seems to be no more than a fine differentiation of the degree of involvement and the stage of the disease. The term *pancreatic necrosis* would seem to be more satisfactory. The clinical picture may be divided into (1) the acute process, and (2) the complications arising from the necrosis.

The onset of pancreatic necrosis is characteristically sudden, following a large meal, an alcoholic bout or previous attacks of biliary colic, or without warning. Severe pain is the outstanding feature. It is located in the epigastrium, in the left hypochondrium, in the back or in both loins. The pain is soon followed by the symptoms of collapse; the pulse is rapid and of poor quality, the blood pressure falls, the temperature may be low, and cyanosis due to collapse may be a striking feature. In other words, there are the symptoms commonly associated with a large hemorrhage together with the agony of a visceral rupture. Vomiting is almost always present early and is repeated, frequent and severe. The respirations may be rapid and shallow.

Upon examination of the abdomen, distention of the epigastrium, with tenderness extending into the back especially on the left side, are prominent features. Rigidity is not usually so striking as in the rupture of gastric or duodenal ulcer. The distention may be so prominent that intestinal obstruction is suggested.

If the patient survives the acute attack, there may be improvement in from three to seven days. Then the temperature rises and the signs of a localized abscess may appear. Vomiting may increase or recommence. The epigastrium may remain full and tender. The symptoms are present of an abscess pointing into the loin, in the subdiaphragmatic region, in the epigastrium or extending into the retroperitoneal tissues and appearing in the scrotum. There may be the symptoms of hemorrhage into the gastrointestinal tract or into the retroperitoneum. The complications recorded in the thirty cases studied, together with those which may occur as indicated by the literature, are listed in table 3.

From table 3 it is seen that the complications are due to fat necrosis resulting from digestion of tissue or hemorrhage following the erosion of a blood vessel. Due to the anatomical posi-

tion of the pancreas, most of the areas of necrosis or the hemorrhages are retroperitoneal and on the left side. If a blood vessel is not opened by digestion, it may become thrombosed. Symptoms resulting from this process will depend upon the vessel occluded.

The conditions that simulate pancreatic necrosis are the following: (1) perforated gastric or duodenal ulcer, (2) biliary colic or acute cholecystitis, and (3) intestinal obstruction. Indeed, one of these diagnoses is usually made when pancreatic necrosis is later found to exist. This is, in no small measure, due to their frequency, as well as the similarity of the symptoms. When confronted with an acute upper abdominal condition, it is necessary to consider pancreatic necrosis in addition to the more common conditions.

TABLE 3

COMPLICATIONS OF PANCREATIC NECROSIS

1. *Author's Series.*	
1. Empyema of Pleural Cavity—Left-Sided.	2
2. Lung Abscess—Left-Sided.	1
3. Abscess in Lesser Peritoneal Sac.	2
4. Retroperitoneal Abscess about Left Kidney.	3
5. Subphrenic Abscess.	3
6. Abscess in Omentum.	1
7. Thrombosis of Splenic Artery	1
8. Hematemesis—Perforation of Stomach.	1
9. Pericarditis.	1
10. Retroperitoneal Hemorrhage.	1
2. *Other Complications.*	
1. *Perforation of Abscess*—Duodenum, Transverse Colon, Common Bile Duct.	
2. *Hemorrhage*—from Intestine, Intraperitoneal from Perforation of Arteries or Veins—Splenic, Pancreatic or Duodenal.	
3. *Thrombosis*—of Portal, Splenic, Mesenteric or Left Renal Vein.	

SUMMARY AND CONCLUSIONS

1. Acute pancreatic necrosis may occur following an acute bout of alcoholism, especially if there is prolonged nausea, vomiting and retching.

2. Pancreatic necrosis and chronic pancreatitis are found in conditions commonly associated with alcoholism, such as cirrhosis and fatty infiltration of the liver.

3. The various circumstances under which pancreatic necrosis occurs are presented together with the diagnostic features and complications as recorded in thirty cases.

4. Attention is called to the conditions in which mild attacks of pancreatitis may be observed.

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ARSENIC POISONING

BY JOHN G. DOWNING, M.D.*

JANUARY 6, 1934, three detail men left samples of so-called tonics at my office, each containing arsenic, one label announcing arsenous acid gr. 1/40 (1.6 mg.) to the dose, to be taken three or four times daily.

Shortly after their departure, a girl presented herself for the treatment of acne. She stated that she had been treated by her family doctor for the past year. At the beginning of the year he prescribed liquor potassium arsenitis in five-drop doses three times a day, and as she had had no relief after faithful ingestion of the above medicine for the full year, she decided to try another physician. At intervals during the year she inquired as to the feasibility of continuing the arsenic but was assured of its value. Lately she noticed that she was feeling quite depressed and languid. Later, upon examining various bottles and packages of pills in the sample closet, it was a revelation to find how many contained arsenic in some form. As a result I determined to report the following case as an example of the result of the injudicious use of arsenic. This routine giving of arsenic for so-called "alterative," "tonic," "roborant," "blood builder" purposes is irrational and harmful.

Arsenic, for many years, was proclaimed the most useful drug in the treatment of skin diseases and has been employed in a large variety of morbid conditions of the skin; it is a useful though much overrated drug and most dermatologists are exceedingly careful in prescribing it. It certainly has a profound influence on the skin for it can produce any form of eruptive disturbance. The cutaneous eruptions from the external and internal use of the drug are similar in character. The irritant effect of external applications has been known since antiquity and cases are on record where arsenical lotions, plasters, and pastes have proved fatal in a very

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short time, so that its use externally is not advised; however, there still crops up a sporadic case where some person has used an arsenic paste on a cancerous lesion.

Fowler's Solution, i.e., potassii arsenitis, is a drug which accumulates in the system and is bound to show itself in various pathologic forms later in life. This preparation was given publicity in the latter part of the Eighteenth Century by an English physician, Dr. T. Fowler, who called it "Liquor Mineralis" to deceive the patients regarding the presence of arsenic; he also reported that urticaria resulted from its use. According to "Remington's Practice of Pharmacy," the formula is as follows:

Arsenic Trioxide	10 Gm.
Potassium Bicarbonate	20 Gm.
Compound Tincture of Lavender	30 cc.
Distilled Water	qs. 1000 cc.

REPORT OF CASE

Mrs. I. F., aged sixty-one, was first seen November 11, 1930; referred by Dr. Joseph Lynch. She complained of itching and blotching of the skin.

Present Illness: The patient stated that for the past seven years she suffered from marked itching of the skin which sometimes broke out into large marks like hives, and at other times left big ridges. This itching was so marked that it kept her awake at night and made her very nervous.

Past History: She stated that twenty-eight years ago she had epileptic attacks for which she was treated by a local M.D. who gave her a medicine which she took continuously until five years ago. It cured her of her epileptic attacks, but she was so afraid of their recurrence that she continued to take the medicine.

Physical Examination: Showed marked eruption on body and extremities; the skin showed various-sized lesions consisting of papules, vesicles, wheals of various sizes, numerous excoriations, and several areas of brownish pigmentation. Examination of the palms and soles showed a different type of eruption; here, the skin was very dry, and there were more or less symmetrically distributed definite hard, keratotic papules surmounted on a skin which was markedly thickened. General physical examination was negative except blood pressure which was 192/86. Briefly, this patient showed typical arsenical dermatitis with keratoses, wheals, papules, excoriated vesicles, and pigmentation.

A copy of the prescription which she took for twenty-three years was secured and was found to be as follows:

Pot. Bromidi	dr. 8
Tinct. Nux Vomica	dr. 4
Liq. Pot. Arsenitis	dr. 2
Aquae	oz. 1
Elix. Gentian & Tr. Ferri Chloridi	oz. 6

This woman had taken over three drops of Fowler's Solution three times a day. She was given various treatments including the use of calcium gluconate and sodium thiosulphate and local applications which gave her some relief from the itching but no improvement of the keratotic lesions; itching was kept more or less under control until her last visit on February 13, 1931. On April 30, 1931, she was seen by Dr. Lynch and at that time, she complained of nausea (one week's duration); her left eye was blurry and she noticed a yellow appearance of her eyes and skin. Five days later she started vomiting; this continued until she was sent to the hospital for further observation. At the hospital, x-ray was employed but showed no definite pathology. The patient was operated upon March 22, with diagnosis of carcinoma at the head of the pancreas, and the question of acute hepatitis. Under spinal anesthesia and with the usual abdominal preparations, a high right paramedian incision was made. The abdomen was opened; the liver was found to be reduced to two-thirds its normal size, and its surface was roughly granular. The gall bladder was not distended and emptied readily. There was no evidence of stones or of common duct obstruction. It was felt that nothing further was indicated from a surgical standpoint and the abdomen was closed in layers. The patient died eight days after operation.

Laboratory Findings: Wassermann—Negative.
Trace of bile in urine.

The above case, as regards the skin, showed a typical eruption due to the ingestion of arsenic, and it was the opinion of the internist and surgeon that the liver changes were also due to arsenic. Whether the arsenic was of value in the original condition it is hard to state, but the continued use of this dangerous prescription could have been prevented by simply adding the words "non-repeat".

MALPRACTICE SUITS, THEIR CAUSE AND PREVENTION

BY HALBERT G. STETSON, M.D.,* AND JOHN E. MORAN, M.D.*

AN analysis of the causes of malpractice suits has been made and the following facts present a summation of information obtained from various liability corporations and physicians.

Approximately twenty thousand suits have been brought against physicians in the United States in the past five years, nearly one thousand of which have occurred in Massachusetts. There are approximately 350 cases awaiting disposition in this state at the present time.†

The causes of these suits, as determined from an analysis of 35,000 cases, are as follows:

1. Inopportune remarks by subsequent attending physicians.
2. Personal enmity and jealousy between members of the profession.
3. Countersuits interposed as a defense against the suit brought by a doctor for the purpose of collecting his fee.
4. Failure to use the x-ray in the diagnosis of, and reduction of, fractures.
5. Outside causes, e.g., newspaper articles, so-called "scientific cults," etc.
6. Negligence of the nurse employed by a physician.
7. Rarely alcoholism.

†Presented for publication January 27, 1934.

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8. Rarely failure to use a method of treatment which is used by the majority or a respectable minority[1].

Physicians are themselves to blame for the greatest percentage of suits. In replies to our inquiries, not one source of information put this cause below 60 per cent, while some placed it as high as 80 per cent. Inopportune remarks must be avoided. One must remember that, whenever a patient is dissatisfied with results, all that is necessary to start a lawsuit is the comment of some doctor, criticizing the work of a previous physician.

A considerable number of these suits are due to the specialist who, though he does not mean to, makes a statement which can easily be construed as meaning that the previously attending physician was negligent. One communication received states, "The specialist is unknowingly and unwittingly drawn into malpractice cases by the simple method of the patient presenting himself at the office of the specialist, often upon the advice of a lawyer who is somewhere in the background. The patient very cautiously gives little, if any, history of the attendance by a previous physician, seeks a diagnosis, which is usually given, and then never comes back. The specialist is very much surprised, in the course of two years, to be summoned as a witness for the plaintiff and have to give up time at the ordinary summons rate."

Inopportune remarks are the result of a lack of proper history taking and a poor knowledge of human psychology. By way of explanation; one has a patient with a poor result; the patient is in a state of self-pity; he then presents himself at the doctor's office. It is just the tone of the physician's voice when he says "Who treated you for this condition?" that increases the sense of self-pity and he brings in a malpractice claim. Then again, we have the type of physician who, without knowledge of the particular type of injury or sickness, or a knowledge of the particular patient that presents himself, will in some way lead that patient to believe that if he had come to him in the first place the present condition would not have occurred.

There is another class of "inopportune remarks" that causes malpractice suits. We have found that any number of doctors have been drawn into malpractice suits by simply answering hypothetical questions put before them by "lawyer friends".

The second group of causes consists of these factors: personal enmity, animosity and jealousy among members of the profession. One source of information writes: "We have seen a great many malpractice cases arise out of a personal enmity between physicians or between divisions of a local medical society. We have always felt that malpractice cases were not the place to get even. A malpractice suit that is successfully prosecuted tends to breed other cases of a similar nature and the activity of a physician in assisting a plaintiff in one case may ultimately result to his own detriment."

Another source states; "Our experience and the impression created in reading the statements of various doctors in regard to these cases in several thousand instances, lead us to believe that this personal equation is one which is a personal factor in causing these suits to be brought." There are many communities where such a feeling exists. One letter states: "There is also a breaking away from the old situation of physician and patient, probably due to a transient or floating population, plus a certain foreign element. With this situation in mind, all physicians should be very guarded in taking a case of another physician. We have noticed, too, that there is a slacking off in the subsequent attending physician calling up the previous physician and telling him that the patient has come under his care. This courtesy of ethics seems to have fallen by the wayside. It is my opinion that, if this little courtesy were adhered to, the average physician would save himself a lot of trouble. In the final analysis, as previously stated, about 65 per cent of the present claims were due to the remarks made by subsequent physicians. Of this amount we would say that at least 45 per cent were incautious remarks, not made with any malicious intent, or even no remarks made at all, but mere gestures or acts of the subsequent attending physician, from which the patient drew an inference that he had been wronged. The other 20 per cent were undoubtedly due to professional jealousy, self-assurance and superiority psychology."

Such statements should make physicians everywhere realize that clean, straightforward adherence to the codes of professional ethics will do much to lessen the incidence of such claims. For men to feel that they possess far greater skill than a group of equally capable men in the same community, is mere conceit. It would be much better for such groups to meet and develop good fellowship than to allow them to remain isolated from each other.

The estimate of counterclaims brought because a physician attempts to collect a bill is twenty per cent. In view of this, it is well to remember the time at which malpractice suits are outlawed. In this state it is two years, though some of our citizens would like to have the time extended.

In the case of fractures, Groves[2] found causes as follows:

"Absence of x-rays

Diagnosis missed	56
Some complication overlooked	18
Malunion not recognised	12
Allegation by hostile practitioner could not be refuted	4
	90
Hostile action based on adverse criticism by another practitioner	10"

He also says, "Unfortunately the practitioner who carries out this treatment is often not content with having secured the patient, but allows himself to express some hostile criticism, or at any rate assents to an opinion expressed by the patient, hostile to the first doctor. This opinion then actually forms the basis of the action for negligence. This factor of one medical man criticizing or condemning another is in reality very much more important than the figure of 10 per cent would indicate. The great majority of all the other 90 per cent of the cases, although they may turn upon the neglect of x-rays, are nevertheless supported by the criticism of one medical man about the conduct of another."

These suits form a very important problem. A recent speaker before the Franklin District Medical Society emphasized the caution that must be observed in caring for fractures. He stated that nearly 90 cases of fractures were pending disposition in malpractice suits in Boston at that time.

In view of the above analysis of 35,000 or 40,000 cases it might be well for members of the profession to remember the statement of Rip Van Winkle, made after one of Dame Van Winkle's outbursts of temper, "A tart temper never mellows with age, and a sharp tongue is the only edged tool that grows keener with constant use." The Greek philosopher, Xanthus, said, "The tongue is the best and worst in man; the best if used all right, the worse if used awry." If these two thoughts are kept in mind we are sure that malpractice suits will show a decided drop. The suggestions of Locke[4] should be always kept in mind, "Please don't criticize—particularly to the patient—the treatment given by some other doctor before the patient came to you. You see the result—nothing more. You do not know the whole story. You do not know what the original condition was, what the other man encountered in the way of difficulties, or whether he had proper coöperation from the patient. Wait 'until the evidence is all in.' You may change your mind when you get all the facts. You may be wiser. But at least, you will know what you are talking about."

Adequate records aid greatly in proper disposition of these cases. To quote Cannon[4] "To eliminate many of these dangers, I caution you as follows:

(1) Relative to your records. From day to day it must become more evident to the practicing physician and surgeon that his only safety against malpractice suits, even though he be guilty of no negligence, lies in keeping an accurate record of his treatment of the patient; not only a correct record in the hospital, but a correct office record of all that transpires outside of the hospital, and not only should he keep a correct record, but he should keep an accurate and detailed record, both in the hospital and out."

Copies of prescriptions should be kept, frequent roentgenograms should be taken; if an operation is performed, the record should show what was removed, what was mended and what was learned. These records should be made at the time, or immediately in one's recollection. In practically all of our malpractice cases, we find our records are not quite so complete as they should be. The writers have had little occasion to complain of the completeness of the records made by the attending nurse, whether it be the day or night nurse; these nurses seem to do their work well and carefully; their charts appear to be complete. But the so-called practical nurses are ignorant and some of them will be very glad of an opportunity to join in an effort to recover against the doctor. I might, therefore, add that in addition to making complete and accurate records, the doctor "keep an eye" on the practical nurse.

Another caution might be suggested, and we approach that question with some misgivings. More frequent consultations should be had, bearing in mind, however, that the patient ought not to be required to pay too many doctors. The consultant ought not to work without reasonable recommendation. Good judgment should be used, and such judgment ought to indicate when a case is sufficiently serious or the family sufficiently dangerous to require consultation, for the protection of the doctor and for the health of the patient.

Secondly: Wherever possible, have pathologic examinations made and records kept. The standardization of our hospitals has done much for you in this department, but all records should be checked from time to time, and it may be that your patient is not in a standardized hospital. Your records can nevertheless be made quite complete if you exercise care.

Thirdly: Do not hesitate to call an honorable and able professional man for consultation. You have nothing to fear from the man of honor and high professional standing. Lawyers do this, business men do it, all do it, and as a rule, the professional man of high ethics and good moral fibre will thank you for calling him, even if the patient is unable to pay, because it enables him to perform that high duty that he owes to humanity.

Fourthly: Secure consent before you operate, and if you have cause for suspicion that the parties are not of good character, require written consent to be signed. In major opera-

tions the patient is under complete anesthesia. The physician may discover conditions not anticipated before the operation was commenced and which if not remedied will endanger life or health. In such cases he may, and perhaps in aggravated cases must, remove the newly discovered danger, but it is always wise to get consent to this action, and the surgeon who does not do so is not using that precaution in his own behalf that bespeaks his care in behalf of others. While the pathologic requirements of the hospital, if the patient is in a standardized one, is some protection, the careful surgeon will require still greater protection, because it is a principle of law that one's body is not to be mutilated in any manner except by one's consent. There are exceptions; for instance, one may be carried to a hospital in an unconscious condition with no one to speak for him; if not operated upon, he may die. But the exception is not the rule.

We do not wish you to believe that it is our view that the physician or surgeon is never at fault. We have lazy doctors as we have lazy lawyers, and others, who neglect their cases as the lawyer neglects his, who fail to keep abreast of the advancement of medical science and skill, as the lawyer fails to read the decisions and takes his cases in a slipshod manner. If his laziness in attending to the case or his laziness in keeping abreast of his profession results in damage to the patient who places himself in his charge, this doctor should be punished, and the way to punish him, outside of your profession, is to make him pay damages. But the best way to punish him is within your organization. Occasionally a good man is unable to defend himself because he has failed to protect himself by keeping records, and is unable to show what he did do.

We now have but 10 per cent left, due to other causes. Cannon seems to sum these up extremely well. "The outside causes of suits against doctors are many. People of the present day, without appreciating the fact that a little knowledge is a dangerous thing, read articles found in newspapers, some of them written by advertising doctors, and think from such reading that they know something about medicine and surgery, and they become critical. The smattering of knowledge that they have leads them to become fault-finders, and they love to profit by their fault-finding.

"Still another cause of trouble is the fake doctor. Never in the history of medicine have we had so many 'isms' in the medical and surgical field. To repeat the scientific names which men and women attach to themselves to fool the public into believing that they have scientific knowledge, would tax one's memory. Many of these affixes or prefixes mean nothing to the educated mind, but mean much to the public. Ignorant people go to these men after they have been ill or have suffered an operation, and they leave firmly convinced that their former physician or surgeon has ruined them forever. These people cause trouble."

To think that because he is insured he does not pay, is incorrect. The policyholder, the one insured, always pays. The truth of this is well shown by the fact that in any form of insurance, if the amount deposited by policyholders is not enough for the company to carry out the agreement, they, the policyholders, must pay more money because the insurance company will be compelled to increase the rate on future insurance. The New Haven Medical Association had this very experience a few years ago. Their insurance company in seven years expended $44,597. The amount deposited by the group with the company was $18,127. The company then notified the Association that payments in future must be four to six times more than had been previously paid.

To say that the incidence of suits cannot be decreased is fallacious. The work of the New Haven Medical Association in decreasing the suits in their territory is commendable. They organized a committee on Medical Ethics and Deportment. The work of this group, and the results, can be best brought out by quoting from a letter received from the chairman, Dr. Frank H. Wheeler: "As to the percentage of suits started by indiscreet or malicious remarks of another doctor, it is hard to estimate. Our committee, as you will note, put it at 75 per cent. I saw an estimate the other day by some doctor as 80 per cent. We found that not only an injudicious word, but even the lifting of the eyebrows or shrug of the shoulders when examining a case treated by another doctor was enough to start a suit. Such an occurrence repeated to a shyster lawyer is often enough to start him making trouble for a doctor.

"Our committee was organized about a year and a half ago. There were several suits then pending. We investigated several of them and gave advice as to their handling. In four cases we advised settlement as the doctor was evidently at fault. One was settled, but the insurance company elected to contest two, and lost them. The fourth has not come to trial. We advised fighting the others. One of these has been tried and the doctor won. The others are resting in abeyance.

"Since the committee was formed several cases have been threatened. We investigated them and advised settlement in one, and in all the others we advised resisting. It would appear that nearly all of these latter have been dropped. No suits have been brought.

"I would call your attention to the name of our committee. It is not a defense committee. We are not appointed to defend a doctor, but when a member of our Association is accused of any misdemeanor we investigate the circum-

stances, talk with him, then advise him as to what we think he should do. If he needs our help we give it, not as a committee, but as individuals. The lawyers here quite generally understand it. In fact, one lawyer called a doctor to his office, told him he had been asked to bring a suit against him and advised him to bring the matter before the committee. He did so and when the lawyer found we had exonerated him, he dropped the case.

"The committee is made up of men who stand very high in the profession and when a lawyer knows that such a set of men have investigated a case and decided that the doctor involved is not guilty of malpractice, he is very shy about bringing a suit. The worth of such a committee has been recognized and now each county has a similar committee and the chairmen of the County Committees constitute a State Committee. A doctor who has a hearing before his County Committee and is aggrieved at their findings, can ask for a hearing before the State Committee."

Conclusions:

1. An analysis of the causes of from about 35,000 to 40,000 malpractice suits has been made.

2. Sixty per cent are the result of inopportune remarks of a subsequent attending physician, either because of the lack of knowledge concerning the facts of a case or because of personal animosity or jealousy.

3. Twenty per cent are counterclaims made because the physician attempted to collect his fee.

4. Ten per cent are due to non-use of the x-ray in the diagnosis and reduction of fractures.

5. Ten per cent are due to outside causes as newspaper articles and so-called "scientific cults," negligence of nurse, alcoholism, failure to use treatment, etc.

6. The following rules are the best safeguards against malpractice.

a. A cautious tongue.
b. Proper use of the x-ray.
c. Accurate and complete records.
d. Adherence to the code of medical ethics and the application of the golden rule in the care of patients who have been previously attended by another physician.
e. A knowledge of the accepted forms of treatment.

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NEW ORDER SPEEDS UP ERADICATION OF CATTLE TUBERCULOSIS IN TWENTY-FIVE STATES

The expansion of bovine tuberculosis-eradication work by the Federal Bureau of Animal Industry, as a part of the emergency animal disease eradication program under provisions of the Jones-Connally act, will be governed by new regulations just approved by the Secretary of Agriculture. The first allotments of these funds, a total of $2,000,000, are for cattle tuberculosis work alone and will be spread over twenty-five states, as previously announced. The regulations, designated as B. A. I. Order 344, specify the method of conducting the work, the basis of making appraisals of tuberculous cattle, and explain the requirements for cleaning and disinfecting premises and conveyances.

The new regulations differ from those used in the regular conduct of the work principally in allowing states to participate in eradication work whether or not they expend any of their own funds for indemnities or for the cost of testing. The total amount received as indemnity from all sources plus the salvage obtained shall not exceed the appraised value or an amount the owner would receive under the existing plan in his state. The payments for cattle found to be tuberculous will be made on the basis of a maximum of $20 a head of Federal money for grade cattle and $50 for registered pure-bred cattle.

MORTALITY RATES

Telegraphic returns from 86 cities, with a total population of thirty-seven millions for the week ending June 9, indicate a mortality rate of 11.4 as against a rate of 11.1 for the corresponding week of last year. The highest rate (20.2) appears for Memphis, Tenn., and the lowest (4.6) for Long Beach, Calif. The highest infant mortality rate (21.4) appears for Spokane, Wash, and the lowest for Cambridge, Mass., Canton, Ohio, Duluth, Minn., Long Beach, Calif., Louisville, Ky., New Haven, Conn., and Somerville, Mass., which reported no infant mortality.

The annual rate for 86 cities is 12.3 for the twenty-three weeks of 1934, as against a rate of 11.7 for the corresponding period of the previous year.

SUMMARY OF DEATHS AND DEATH RATES (ANNUAL BASIS) FROM AUTOMOBILE ACCIDENTS PER 100,000 ESTIMATED POPULATION FOR 86 CITIES FOR CORRESPONDING PERIODS OF 1934 AND 1933

	Week ending June 9 1934	Week ending June 10 1933	First 23 weeks 1934	First 23 weeks 1933
Total deaths	162	140	3,627	3,167
Death rate	22.6	19.5	22.0	19.2
Deaths due to accidents in city	118	111	2,921	2,538
Death rate	16.4	15.5	17.7	15.4

—*Bureau of the Census.*

BACKWARD DISPLACEMENT AFTER ANKLE FRACTURE

Corrective Operations

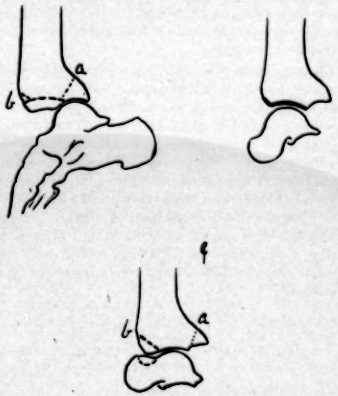
BY FREDERIC JAY COTTON, M.D.,* AND GORDON MACKAY MORRISON, M.D.*

NOT unusually fractures at the ankle with backward dislocation of the foot† are followed by crippling disability.

The problem of relief forces us to define two classes:

1. Those in which backward dislocation of the foot and fragment give an inadequate (often unstable) weight-bearing joint with malleoli much displaced, and
2. Those with a decent enough, though not normal, weight-bearing joint disabled by painful contact at the front of the joint on motion, in dorsiflexion.

For the first class nothing is of avail save an extensive reconstruction of the whole ankle, a useful operation, though formidable. The malleoli are divided at the joint level, and from the cut of the outer malleolus, the joint is opened horizontally forward. The malleolus then dragged down a bit gives access to the side of the tibia. With a large chisel (of wide curved concavity) a single cut is made horizontally across the joint, leaving a quarter cylinder concave cut (see first illustration) for the astragalus to set into. The next step is to loosen up the whole joint. This means extensive ligament tearing by *external* force or (not so good) instrumental leverage *within* the joint. This must be complete enough to allow of the astragalus being dragged forward (see second illustration) to a proper position. Sometimes the malleoli must be refitted. Pins or the like are not needed. Inasmuch as the cartilage of the top of the astragalus is not cut and should not be bruised, direct ankylosis does *not* occur. The results are rather better than one might reasonably expect. In the lesser cases, the remedy is less. One need only abolish the check to dorsiflexion. That means an incision on the outer side of the joint, a thin osteotome slipped in so sloped as to clear a generous wedge straight across the front of the tibia. (See lower figure of illustration.) If possible this should be a matter of one cut, with removal of the wedge in one piece. If there has been much irritating contact the neck of the astragalus may show overgrowth, and may be dug away, liberally. One need not fear ankylosis for there is no longer any bone contact. The only chance is of a recurrence of bony overgrowth. As a rule the operation, very simple as it is, is well worth while.



TYPE III.—COTTON FRACTURE.

Upper figure: left—
(a) shows the approximate line of the posterior tibial fracture.

The astragalus is in contact with the rear fragment, but out of weight-bearing contact with the main articular surface of the tibia. Dorsal motion absolutely blocked.

A new curved articular facet is cut in the tibia (b) to receive the top of the astragalus.

Upper figure: right—
This cylindrically concave surface is shown by the heavy line. Into it the astragalus is fitted. No attempt is made to move or remove the projecting (and very inaccessible) posterior fragment.

Lower figure:
(a) line of break, (b) edge of tibia removed to clear dorsal flexion,—and with it, a space gouged out of the astragalus to give more room.

†The type sometimes called Cotton's fracture.

*Cotton and Morrison—For records and addresses of authors see page 817, issue of April 12, 1934.

IMAGINARY ILLS

In an address before the American College of Physicians at its recent meeting, Dr. Edward Weiss of Philadelphia stated that a large number of people believe that they are ill, but without any real basis for this fear. This opinion was based on the results of a poll of medical school professors who have found that thirty-five per cent of those seeking professional help were the victims of emotional problems.

Many operations have been performed to rid patients of imaginary troubles, according to Dr. Weiss. He cited one case of a young woman who was subjected to four operations because of symptoms which had no pathological evidence of organic trouble. In this case the symptoms were brought out by the fact that all of her sisters were married and the patient feared that she would have to remain a lonely spinster.

This seems to indicate that her surgeons had no adequate knowledge of the necessity of the services of the psychoanalyst, and sustains the contention that psychiatry is a neglected subject in medical education.

CASE RECORDS
of the
MASSACHUSETTS GENERAL HOSPITAL

ANTE MORTEM AND POST MORTEM RECORDS AS USED IN WEEKLY CLINICAL-PATHOLOGIC EXERCISES

EDITED BY RICHARD C. CABOT, M.D.
F. M. PAINTER, A.B., ASSISTANT EDITOR

CASE 20261

PRESENTATION OF CASE

A fifty-six year old American widow entered complaining of pain in the lower abdomen of six weeks' duration.

Six weeks before admission the patient awoke at night with severe griping colicky pain across the lower abdomen. She vomited small amounts of frothy fluid. During a bowel movement that evening she had excruciating colicky pain in both lower quadrants running down over the pubic region, more marked on the right, with some radiation throughout her entire abdomen. She had no urinary disturbance except slight frequency. There was no burning or urinary clouding. She continued to have similar attacks of pain during the intervening six weeks, and took considerable morphine for relief. Associated with this pain she had increased constipation, her bowels moving only once in three or four days despite the taking of cathartics. For the past two weeks she had had a slight dry cough and for the past week a small amount of ankle edema. One week before admission while lying in bed she found that she could not use her right leg because of severe groin pain. During the past four days the lower abdominal pain had become more severe and had been associated with marked tenderness in the right lower quadrant, flank and groin. The bowels moved slightly, with apparently normal feces. Two days before admission she vomited a small amount of light frothy fluid during an attack of abdominal pain.

The patient had had diabetes for fifteen years and had been given a diet with instructions for testing her urine. Under this régime her urine had been sugar free for about half the time and slightly positive for the remainder. She had had a little burning upon urination, but no clouding of the urine.

Her family and marital histories are non-contributory.

Physical examination showed a fairly well developed and nourished woman appearing acutely ill. The pupils were small and reacted sluggishly. The upper teeth were false. The tongue was coated. Examination of the chest was negative. The blood pressure was 125/80. The abdomen was moderately distended and tympanitic. There was extreme tenderness over the right lower quadrant, flank and costovertebral angle. There was moderate tenderness in the right inguinal region, but no evident glandular enlargement. Peristalsis was normal. Rectal examination showed a small external hemorrhoidal tab. There were marked tenderness and spasm high up on the right. Pelvic examination showed extreme tenderness and firm resistance high up on the right. There was moderate edema of both lower legs.

The temperature was 101.1°, the pulse 100, the respiration 20.

Examination of the urine showed a slight trace of albumin and a slight trace of sugar. There was a very small amount of acetone, but no diacetic acid. Examination of the blood showed a white cell count of 58,000. One examination of the stool was guaiac-negative. A Hinton test was negative. The blood sugar was 200 milligrams per 100 cubic centimeters, the non-protein nitrogen 32 milligrams, the carbon dioxide combining power 58.2, the serum protein 6 per cent.

A flat x-ray film of the abdomen showed an enormous amount of gas in the colon extending from the splenic flexure to the cecum.

Operation was performed. She did poorly after it. Her white cell count was 26,600. A red blood cell count done on the day following operation was 2,750,000, with a hemoglobin of 35 per cent. A transfusion was done. Her diabetes was fairly well controlled, but she became semicomatose and died four days after admission.

X-RAY INTERPRETATION

DR. TRACY B. MALLORY: Will you comment on the x-ray films, Dr. Holmes?

DR. GEORGE W. HOLMES: This film shows a distended large bowel. The distention is most marked in the cecum and ascending colon and apparently stops rather abruptly near the splenic flexure. There is gas beyond this bowel, but I think it is in the small bowel.

DR. HENRY H. FAXON: Dr. Holmes, could you see diverticula without barium in a film of that kind?

DR. HOLMES: I think not.

In addition she has marked calcification of the pelvic arteries and a shadow in the pelvis which might be a calcified fibroid.

I should like to be able to go a little farther in an attempt to locate the obstruction. If this were large bowel we should expect to see the haustral formation in it that we see here. This is distended bowel, not paralyzed bowel. If the obstruction were low down we should expect gas to show in the whole length of the colon. It would seem that if there is an obstruction it must be above the pelvic rim.

Further History

The operation was incision and drainage of a retroperitoneal abscess in the right flank.

Differential Diagnosis

Dr. Faxon: The time is short and this case is similar in many respects to the one we have already heard, so I will go through it rapidly.

She had colicky pain that came on at night and was severe enough to wake her. In a woman of fifty-six large bowel obstruction is the first thing that comes to mind.

"She vomited small amounts of frothy fluid." Frothy fluid is mentioned again in the history. I can attach no especial significance to it except that each time it is mentioned it is associated with the pain, does not persist, and is not a very striking feature.

The bowel movement seems to have given rather than relieved the pain. If the person was having obstruction, as has been said before, one might expect that an evacuation might well relieve her. In this case she had even more pain, and we think of perforation.

This condition lasted for six weeks, which means that the obstruction must have been partial rather than complete. She had increased constipation, which is to be expected if our diagnosis is correct.

There is no mention in the history of any blood in her stools at this or any other time.

The pain started six weeks before she came in, but one week before she came in she developed a process in the right lower quadrant which was enough to restrict the motion of the leg, was very tender and gave later a high white cell count and temperature.

There was no attempt made to correlate the colicky pain with peristalsis, but certainly from the examination and from the fact that peristalsis was, as noted here, "normal", it would seem that the inflammatory process in the right lower quadrant was a local rather than a general peritonitis, and the obstructive element mechanical rather than inflammatory in origin.

I do not think the mass and the inflammatory process play a part in the edema of the extremities, but think this was due to general conditions of her illness and long-standing sepsis.

She had enough infection to raise her temperature to 101°, and yet the pulse, in a fairly elderly woman, was not over 100.

The white blood cell count was 58,000. That brings us up with a start. Either the count was incorrect, which I suppose I should put down as the last possibility, or else she had some localized shutting down of circulation with resulting gangrene. We might say that the white cell count was due to infection alone, but in an old woman it seems high. Possibly she had some blood disease, but we are given no other information to bear this out.

From the story so far she has had enough lower abdominal cramps to make me think that an obstruction of the large bowel would have to be well along in the large bowel. I was attempting to make the cause of the obstruction and the mass in the right lower quadrant one and the same; yet, if it were, she would not have given this x-ray picture and her story would have been different.

"Incision and drainage of a retroperitoneal abscess in the right flank was performed." I wonder if that statement is correct. I wonder whether that might have been a retroperitoneal drainage of an abscess that did not necessarily start retroperitoneally. The question comes up as to whether she had a retroperitoneal mass in the first place causing obstruction from extrinsic pressure on the bowel. I should not think that was likely.

The low red cell count and hemoglobin, it seems to me, can be accounted for either by malignancy or almost equally well on the basis of long-standing chronic sepsis.

To sum up, we know she had diabetes which was under control. We know she was at an age when she would probably show the changes of long-standing severe sepsis and the changes one might expect in a woman of her years. I think that the picture is that of large bowel obstruction with the lesion in the region of the splenic flexure. I picture the situation as being this. She developed obstruction which either perforated into the general peritoneal cavity and walled off, or else perforated retroperitoneally, and thus gave rise to the inflammatory mass in the right lower quadrant. Any such mass in the right lower quadrant certainly by the law of averages should be an appendix that had ruptured. Yet despite what Dr. Jones brought out in the other case it seems to me she has had too much crampy pain to suppose this to be a case of an appendix that had ruptured. As to the cause of obstruction in the large bowel, we come down to the two favorites of the day, cancer or diverticulum. The story leaves the left lower quadrant free from symptoms. That should exclude diverticulum, and yet she had no bleeding from the rectum, which one might expect with cancer. I would put my final diagnosis down as obstruction of the large bowel due to diverticulum with perforation in the region of the ascending colon and cecum which went on to abscess formation and was drained retroperitoneally.

I do not know the immediate cause of death, but I think she died from the combination of all she had been through rather than from any terminal event.

Dr. Franklin G. Balch, Jr.: My diagnosis in this case was an abscess in the right lower quadrant of unknown origin. It was obvious where the incision was to be made in this case. A right-sided incision was done, coming down on an inflammatory edematous mass. On exploring further the abscess was found to be retro-

peritoneal, extending up toward the kidney and down behind toward the bladder. As we could not find out where it came from, we put in a drain below and a drain above and closed the wound.

CLINICAL DIAGNOSES

Retroperitoneal abscess.
Diabetes.

ANATOMIC DIAGNOSES

Adenocarcinoma of the sigmoid with metastases to the heart.
Perforation of tumor with large right retroperitoneal abscess.
Operative wound, drainage of right retroperitoneal abscess.
Necrosis of right psoas and quadratus muscles.
Adenomatous polyp of the sigmoid.
Cervical polyp.
Hemangioma of the liver.
Arteriosclerosis, moderate aortic and coronary.
(Diabetes mellitus.)

PATHOLOGIC DISCUSSION

DR. MALLORY: The autopsy showed of course the retroperitoneal abscess which Dr. Baleh described. It involved the entire right side of the posterior abdominal wall, going up as far as the kidney and at its lower extremity apparently perforating into the pelvis. There was no generalized peritonitis.

The source of the abscess was at first puzzling until we found a carcinoma of the sigmoid which had ruptured retroperitoneally and the pus had drained around the pelvic brim behind the peritoneum and up on the right side instead of on the left, where one would expect it in a case of rupture of the sigmoid.

A SURGEON: Was the cecum perfectly intact?

DR. MALLORY: Yes. The appendix was also normal, though it lay in immediate apposition to the pelvic portion of the abscess.

An oddity of the case was the finding of a single metastasis in the heart muscle.

CASE 20262

PRESENTATION OF CASE

First admission. A sixty year old Irish janitor entered complaining of a productive cough.

For the past ten or fifteen years he had had colds associated with cough and wheezing during the autumn. These attacks would usually disappear toward Christmas. This condition came on as usual four to six weeks before admission and became worse. It consisted of a rather severe cough with occasional blood streaked material. There was no pain in the chest. There was some wheezing and some watering of the eyes. During the past year he had become considerably weaker and for the past four weeks had noticed a tightness in the left epigastrium. He had lost ten or fifteen pounds during the past year.

Family history. His father was dead; cause unknown. His mother died of pneumonia. There was no family history of tuberculosis, cancer, asthma, hay fever or diabetes.

Marital history. He had been married twenty-six years. His wife and two children were living and well. There had been no miscarriages.

Past history. Twenty-five years before admission he had worked in a gold mine in Australia for a period of four years. During the past few years he had been a janitor. His work consisted in taking care of furnaces among other things. The gas fumes from the furnaces had always aggravated his condition. He did not remember any childhood diseases. He had had some rheumatism, and about five years before entry had all of his teeth pulled with some relief. While in Australia he had had typhoid fever. He believed he had some pleurisy on the left side five years ago. This was characterized by pain in the chest with breathing.

Physical examination showed a poorly developed and emaciated man. There were small pea-sized glands in the right axilla and the right epitrochlear and inguinal regions. His chest was flat, with a depressed xiphoid. The expansion on the right side was greater than on the left. Throughout both apices there were fine and medium râles, more marked on the left. Throughout both lung fields there were inconstant sibilant râles. At the left apex the breath sounds were bronchial in character. Tactile fremitus and spoken voice were increased. The heart sounds were of good quality. There were no thrills or murmurs. The blood pressure was 128/80. The ankle jerks were absent.

The temperature was 98°, the pulse 60, the respiration 20.

Examination of the urine was negative. Examination of the blood showed a red cell count of 4,450,000, with a hemoglobin of 60 per cent. The white cell count was 6,300, 75 per cent polymorphonuclears, 20 per cent lymphocytes and 5 per cent large mononuclears. The sputum was fluid and showed a few Gram-positive cocci in chains, some elastic tissue and very few cells. No tubercle bacilli were found. One of two stool examinations showed a positive guaiac. The Hinton was negative. The non-protein nitrogen of the blood was 38 milligrams. A tuberculin test of 1-1000 was negative in forty-eight hours.

X-ray examination. The upper three fourths of both lung fields showed dense mottled dull-

ness with definite evidence of fibrosis and distortion of the upper mediastinum and of the cardiac shadow, with evidence of thickening of the pleura in the entire right axillary border and the upper half of the left axillary border. The mottled areas in the lungs were quite dense and equal to that of the ribs. No definite cavity was visualized.

He improved somewhat on bed rest and was discharged to the Outpatient Department on the thirteenth day.

History of interval. He gained a few pounds for the first month after discharge, but afterwards lost about five pounds. He felt well during the summer, but after the onset of the cold weather his wheezing returned, along with increasing dyspnea and cough. For the past two weeks before his second entry he coughed up about a tablespoonful of gray-white material daily. At the time of readmission he was quite weak. He was seen in the Outpatient Department several times during the interval. His condition in general remained about the same. He entered the Emergency Ward on his own initiative because of weakness and dyspnea.

Second admission, a year and two weeks after his previous discharge.

Physical examination. The physical signs in his chest were as follows. The trachea was displaced to the right. There was dullness with increased tactile fremitus and bronchial breath sounds in the right upper lung field. In the left upper lung field tactile fremitus and breath sounds were absent; spoken voice and whispered voice were decreased. The rest of the examination was as at his previous admission.

Laboratory examinations were about the same as at his previous admission.

X-ray showed that there had been a marked change in the appearance of the lung fields since the previous observation. The left lung was now completely collapsed. The right lung was still fibrosed and showed unusually dense markings. There was no evidence of cavity. The density of the right upper lobe was that of the ribs.

Five days after admission 600 cubic centimeters of air was removed from the left chest with some relief. An x-ray film on the following day showed that there had been no re-expansion of the collapsed lung. He rapidly failed, and died ten days after admission.

Differential Diagnosis

Dr. Donald S. King: The summary of the history is that of a man of sixty who twenty-five years ago worked for four years in a gold mine in Australia. Of course we cannot throw out that occupational story. He was apparently well for ten years; then about fifteen years before admission he began to have autumnal attacks of cough with expectoration and wheezing. My allergic training will not allow me to pass by that picture of seasonal asthma. It is of course a common story with a ragweed pollen sensitization; but as we go on with the history I do not believe that we can place much emphasis upon a possible sensitization in this case. The story of repeated attacks in the autumn, clearing by Christmas time, is nevertheless interesting.

He had had pleurisy five years before. The present illness showed weakness, weight loss, cough, sputum, and dyspnea.

Following discharge from the hospital he was better—in fact, almost well—but by the next autumn he again had weakness, dyspnea, and cough and had had some bloody sputum. At the second admission he had the physical signs and x-ray evidence of spontaneous pneumothorax at the left apex.

On the basis of the history, then, of pleurisy, hemoptysis, and spontaneous pneumothorax, our first thought is tuberculosis. The physical signs of moist râles at both apices are consistent with such a diagnosis. The sibilant râles throughout the chest could be explained on this basis.

Laboratory examination, however, does not support the diagnosis of tuberculosis. No tubercle bacilli were found in the sputum. A negative intradermal tuberculin test with a 1-1000 dilution is significant. A test should have been done with a 1-100 dilution, but it would probably have been negative.

I am interested in the report of elastic fibers in the sputum. In these days we have almost forgotten to look for these fibers in a sputum examination. In spite of the record, I doubt their presence in this sputum, because a sputum described as fluid and containing almost no cells would rarely if ever contain elastic fibers. If elastic fibers are present it is of course definite evidence of lung destruction such as is present in lung abscess; but under the present conditions I am going to assume that elastic fibers were not present.

The first impression one gets from the x-ray film is of silicosis rather than tuberculosis or other pathological process. Uncomplicated tuberculosis could perhaps give this x-ray picture, but I believe the shadow is too dense to allow of such an interpretation. A malignant process should be considered, but certainly the x-ray picture is not typical of such a process.

On the basis of the occupational history, symptoms, laboratory findings, and x-ray I would then make a diagnosis of silicosis. The particular problem in differential diagnosis is whether we are dealing with silicosis alone or silicosis plus tuberculosis.

The history is a little unusual in that his exposure occurred twenty years before his hospital entrance. He worked for only four years and then had no lung symptoms until many

years later. This is, however, not a particularly uncommon story in silicosis with or without tuberculosis. We certainly lack any definite evidence of tuberculosis; but the literature reports a number of cases free from tubercle bacilli during life which showed tuberculosis at autopsy. It is true also that many of the men who have reported cases have felt that "massive fibrosis" as shown in the x-ray plate practically always means that there is an associated tuberculosis.

I shall be interested in getting Dr. Alton Pope's reaction on this problem, since in his capacity as Director of the Tuberculosis Division in the Massachusetts State Department of Health he has for the past year been engaged in a study of the silicosis problem in Massachusetts with especial reference to the association of silicosis and tuberculosis. I showed him this film yesterday and I believe at that time he felt that the x-ray findings could be explained on the basis of silicosis alone. The problem has become an important industrial one in this State as elsewhere, and the special Industrial Disease Commission with which Dr. Pope has been working has presented a two hundred and fifteen page report to the Legislature. The present rates for employers' insurance in the granite and foundry industries are now exorbitant. As I understand it, for every one hundred dollars paid in wages ten dollars has now to be paid for insurance. Is that correct, Dr. Pope?

DR. ALTON S. POPE: Twelve dollars out of every hundred and a deposit of two hundred dollars to start with.

DR. KING: This is a very high insurance rate, and the problem is of course of pressing importance.

Another diagnosis which one should consider briefly is malignancy. It is of course interesting that carcinoma of the lung has been said to occur so frequently in miners; but in the two groups reported in the Schneeberg mines and in the mines at Joachimstal the miners were probably working with a radium bearing ore whose effect would be different from that of the gold ore in Australia. In this particular case, however, I see no reason for making a diagnosis of carcinoma.

My diagnosis is silicosis plus tuberculosis, the diagnosis of tuberculosis being added on the law of chances rather than because there is any definite evidence of tuberculosis in this case.

A PHYSICIAN: Is spontaneous pneumothorax apt to occur in straight silicosis cases?

DR. KING: I do not think it is common, but I have seen cases. A great many cases do have it, but that is usually said to be due to tuberculosis. I shall be very much interested to know whether this was silicosis alone or silicosis and tuberculosis.

DR. TRACY B. MALLORY: Dr. Pope, have you anything to add?

DR. POPE: I think I have very little to add to what Dr. King has said. Unfortunately I missed the first part of the history.

The negative tuberculin is I think very important in this case. Of course if it were tuberculosis and silicosis, though, it would be entirely possible to have a negative test with as advanced a stage of the disease as this apparently is.

I think the roentgenological findings are consistent probably with either advanced silicosis or advanced silicosis with tuberculosis. It is extremely difficult in some of these cases with so much involvement to say we have a superimposed tuberculosis.

The history in regard to the length of time between exposure to silica dust and the development of the disease is not unusual in silicosis. I remember particularly a case I saw in the Outpatient Department, a sand blaster in Lynn. He left there in 1919 and worked as a truck farmer. In 1922 he came into the hospital with far-advanced silicosis and tuberculosis. The symptoms dated a year before he came in here.

I agree with Dr. King that the case under discussion to-day is advanced silicosis, probably complicated with tuberculosis, but I think we shall have to rely on the autopsy in regard to the last point.

DR. KING: I might show you an x-ray film of another case that was proved to be silicosis and tuberculosis. The x-ray appearance in this case is somewhat different from the one we have been discussing and there is unquestionably a large cavity present which looks like tuberculosis. The sputum was full of tubercle bacilli and the patient died of hemorrhage.

DR. J. H. MEANS: I should like to ask Dr. King or Dr. Pope whether the increasing number of judgments in favor of employees have forced employers to take any better precautions against the development of silicosis, or to diminish the exposure to silica dust in the workrooms.

DR. KING: Dr. Pope has had much more experience along that line and can answer the question far better than I.

DR. POPE: Two or three years ago one firm in Massachusetts had a consultation with Dr. Drinker, and under his direction has installed a dust removal system that has given very satisfactory results. This is the only granite plant in the State that has a really effective exhaust system. Most firms have installed exhausts on their surface-cutters, as required, but on inspection it was often found that the dust was discharged where it was carried back into the shed. In Quincy most of the firms have dropped compensation insurance, and are running the risk of suits at common law.

It is only in the past two or three years that the hazard from silicosis in foundries has been generally recognized. In our examination of

some 1,600 foundry workers we found about 9 per cent had evidence of silicosis alone and an additional 2.5 per cent silicosis complicated with tuberculosis. That is about one-half the frequency of silicosis and tuberculosis found in granite workers.

CLINICAL DIAGNOSIS (FROM HOSPITAL RECORD)

Silicosis.

ANATOMIC DIAGNOSES

Silicosis.
Pulmonary emphysema.
Pneumothorax, left.
Pulmonary collapse, partial, left.

PATHOLOGIC DISCUSSION

DR. MALLORY: The autopsy on this man showed, so far as I have been able to make out, pure silicosis. I have the lungs here and I will pass them around. The major portion of his upper lobes and a very large portion of both lower lobes were absolutely atelectatic, and of a firmness which varies from that of shoe leather almost up to rock. It is extraordinarily dense material. In some places, for instance at this apex, there is hardly an alveolus left—perfectly solid tissue. In the remaining portions of the lung, as one would expect, there is a well-marked emphysema. The persisting alveoli for the most part are dilated up to three, five or ten times the normal size.

A SURGEON: Did you find the rupture that caused the spontaneous pneumothorax?

DR. MALLORY: We did not. There were innumerable emphysematous blebs, from any one of which it could have occurred. At the time of autopsy the pneumothorax had practically resolved.

I will take a minute to show the sections. These pink whorls of dense fibrous tissue are very characteristic of silicosis, and as I move the slide around you can see how densely they are packed. They lie almost invariably in interlobular septa in the early stage; one can trace out the lymphatics of the lungs very accurately by the presence of these nodules in and around them. In between these areas there is an extreme degree of emphysematous dilatation of the alveoli. Besides the silicosis there is a distinctly more marked degree of anthracosis than usual, possibly related to his terminal period as a janitor.

The blood vessels throughout the lung, but particularly in the neighborhood of the most involved areas, show extreme degrees of intimal thickening. Here is one artery in which less than one fifth of the lumen is still patent.

DR. KING: Do you think he had elastic fibers in his sputum?

DR. MALLORY: I doubt it very much. There is no active destruction of lung tissue going on anywhere.

DR. MEANS: I should like to ask whether his vital capacity was ever determined.

A HOUSE OFFICER: No, sir.

DR. MEANS: I think vital capacity ought to be measured in cases of this kind, because it is a quantitative measure that throws some light on the degree of limitation of an important function.

DR. MALLORY: My impression at autopsy was that one could hardly get a lower vital capacity than this man would have shown.

DR. MEANS: Dr. McCann of Rochester is attempting to work out a ratio between residual air, which can be measured without too much difficulty, and vital capacity, in silicosis, because he believes that an index may be obtainable which will be useful in an objective way for determining the degree of limitation, evidence that will be valuable when these cases come up in court.

A STUDENT: How often do you get hemoptysis with silicosis?

DR. MALLORY: Perhaps Dr. Pope will answer that.

DR. POPE: I do not know. We do get cases, but we examine men who are actually working. Few give histories of hemoptysis.

DR. MALLORY: One rather interesting thing is that with this tremendous pulmonary involvement, fibrosis in some areas, emphysema everywhere else, and marked pulmonary arteriosclerosis, his heart weighed only 250 grams and the right ventricular wall measured only 6 millimeters in thickness. That was proportionately a little high perhaps for so small a heart, but would certainly not justify the diagnosis of cor pulmonale.

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THE ANNUAL CONGRESS ON MEDICAL EDUCATION, LICENSURE AND HOSPITALS

ONE of the interesting and informative publications of the year is that of the Proceedings of the Annual Congress on Medical Education, Licensure and Hospitals. It should be carefully read by those who are interested in the purposes of the several organizations taking part in this Congress.

As for medical education, great changes have taken place, first, in the elimination of most of the commercial medical schools in existence at the beginning of the present century, secondly, in the consolidation of some weaker schools, and thirdly, in the establishment of classifications of all of the institutions engaged in teaching medicine. It is thereby apparent from the report of Dr. Ray Lyman Wilbur that there has been insufficient progress in bringing a considerable proportion of medical schools up to satisfactory standards in that there is a great disparity in the quality of teaching even in the Class A schools. This seems to be as great as the difference in quality which existed in a comparison of the Class A and Class C schools at the time of the early classification of these institutions.

Dr. Wilbur contends that the time has come when the lower grade A schools should not stand on a statistical parity with those of higher rank and that one imperative problem is to bring the now doubtful Class A schools up to equal standing with those in the higher level, for it is apparent that the finished products of our medical schools should stand on a practical level of excellence. The intimation expressed by Dr. Wilbur is that the laboratory made the medical schools improve the quality of instruction just as scientific medicine has raised the average quality of medical practice.

Fortunately there is an abundance of good medical education and some weak and struggling schools should either be made to develop adequate teaching methods or cease to function.

The demand of the present age is to provide the country with competent administrators of the art of medical practice.

The establishment of standards on paper will not be effective unless the several states confer on the administrators of the statutes authority to enact laws which will compel medical schools to improve their curricula so that they will conform to the recommendations of the Council on Medical Education and Hospitals. While the majority of the states may adopt the recommendations of the Council, the indisposition of some legislatures to confer the requisite power on departments of education or boards of registration to inspect medical schools, with authority to act, will prevent the general adoption of the standards of the Council.

The difficulty lies in the indifference of the people with respect to the questions involved and the remedy depends on an aroused public understanding of the advantages of scientific medicine which will impress the legislatures with the wisdom of better standards.

Efforts in this direction in some sections have not been effective and other methods than those now employed seem to be necessary. In order to overcome legislative inertia a well-planned campaign must be conducted. In so far as the medical profession is responsible for this legislative apathy in Massachusetts, the *Journal* suggests that the deans of our Class A medical schools appeal to their graduates to unite under the leadership of the Massachusetts Medical Society Committee on Legislation in an effort to instruct the members of the General Court on the economic importance of the administration of the health problems of the state through a higher average of practitioners. Standards of

practice depend on the finished product of medical schools to a large degree. Can the Committee on Legislation feel sure of the united support of graduates of Class A medical schools? It has not been in evidence hitherto.

INCREASED HOSPITAL BEDS FOR TUBERCULOSIS

A THREE-YEAR survey of tuberculosis sanatoria throughout the United States just completed by The National Tuberculosis Association, reveals that general hospitals are opening their doors to tuberculosis cases, increasing facilities are being provided for the care of tuberculous children, and 6,863 new beds for treatment of the disease have been added to the nation's public health armament despite the depression.

These data which have been compiled in the form of a sanatorium directory listing facts about 659 institutions containing a total of 86,917 beds, show that there are now available in the United States, 64 federal institutions containing 11,431 beds; 357 state, county and municipal institutions containing 56,940 beds; 73 private institutions containing 4,344 beds, and 165 semi-private institutions containing 14,202 beds.

According to Dr. Kendall Emerson, Managing Director of the National Tuberculosis Association, the significant aspects of the study are the increase noted in the provision made for children in sanatoria throughout the country and the increasing number of general hospitals that are admitting tuberculous patients. Thus, in Idaho, as a substitute for a state sanatorium, provision has been made to care for tuberculous patients in properly equipped units of two general hospitals; general hospitals are being used extensively to provide beds for terminal and convalescent cases in Detroit; and Chicago, Cleveland, and Philadelphia have opened hospitals for convalescent cases.

This change in attitude has been brought about partly by the increasing use of chest surgery in the treatment of tuberculosis.

THE APPOINTMENT OF DR. OVERHOLSER

GOVERNOR Ely nominated Dr. Winfred Overholser to the position of Commissioner of Mental Diseases, and the Council under suspension of the rules confirmed the action of the Governor.

The opportunity for this appointment came with the resignation of Dr. James V. May, who wished to return to his former position of Superintendent of Boston State Hospital. Dr. May's administration as Commissioner was a noteworthy continuation of the policies which have added to the prestige of Massachusetts in the care of the mentally ill.

Dr. Overholser has been advanced from the position of Deputy Commissioner and is well equipped to take full charge of this next to the largest department of the state. Its importance consists in the oversight of sixteen institutions dealing with mental diseases, and twenty-one private hospitals. The personnel in this department includes one hundred and eighty physicians, all of outstanding ability, and about five thousand other employees. In addition to an annual expenditure of about eight millions, about seven millions are in progress under the P. W. A., and expansions in various ways.

Even with these large expenditures the several state institutions are overcrowded, but according to statements accredited to Dr. Overholser, this is not because mental diseases are increasing. It may fairly be assumed that Massachusetts is trying to care for all cases which may need institutional treatment. Dr. Overholser has the benefit of a previous liberal and professional education and long experience in the field of mental diseases.

One especially important characteristic of Dr. Overholser is his desire to cultivate, among the family physicians, more interest in psychiatry; because here, as in other fields of medicine, the opportunity to seek for prevention and early treatment should be recognized by the general practitioner.

The appointment is highly creditable, and Massachusetts may look forward to progress in dealing with the problems of mental disorders.

THIS WEEK'S ISSUE

CONTAINS articles by the following named authors:

PUTNAM, TRACY J. M.D. Harvard University Medical School 1920. Professor of Neurology, Harvard Medical School. Visiting Neurologist, Boston City Hospital. Associate Surgeon, Children's Hospital, Boston. His subject is "Treatment of Hydrocephalus by Endoscopic Coagulation of the Choroid Plexus: Description of a New Instrument and Preliminary Report of Results." Page 1373. Address: Boston City Hospital, Boston, Massachusetts.

MYERS, WALTER K. B.S., M.D. Johns Hopkins University School of Medicine 1929. Assistant in Medicine, Harvard Medical School. Resident Physician, Thorndike Memorial Laboratory, Boston City Hospital. Address: Boston City Hospital, Boston, Massachusetts. Associated with him is

KEEFER, CHESTER S. B.S., M.S., M.D. Johns Hopkins University School of Medicine 1922. Assistant Professor of Medicine, Harvard Med-

ical School. Associate Physician, Thorndike Memorial Laboratory, Boston City Hospital. Address: Boston City Hospital, Boston, Massachusetts. Their subject is "Acute Pancreatic Necrosis in Acute and Chronic Alcoholism." Page 1376.

DOWNING, JOHN G. A.B., M.D. Harvard University Medical School 1915. Assistant Professor in Dermatology, Tufts Medical School. Assistant in Dermatology, Harvard Medical School. Assistant Dermatologist, Boston City Hospital. Dermatologist, Beth Israel Hospital. His subject is "Arsenic Poisoning." Page 1380. Address: 520 Commonwealth Avenue, Boston, Massachusetts.

STETSON, HALBERT G. M.D. University of Maryland School of Medicine and College of Physicians and Surgeons, 1895. F.A.C.S. President Massachusetts Medical Society 1931-1933. Surgeon, Franklin County Public Hospital. Address: 39 Federal Street, Greenfield, Massachusetts. Associated with him is

MORAN, JOHN E. M.D. University of Maryland 1927. Surgeon, Franklin County Public Hospital. Address: 39 Federal Street, Greenfield, Massachusetts. Their subject is "Malpractice Suits, Their Cause and Prevention." Page 1381.

COTTON, FREDERIC JAY, M.D. AND MORRISON, GORDON MACKAY, M.D. See page 817, issue of April 12 for records of authors. Their subject is "Backward Displacement After Ankle Fracture." Page 1386.

MISCELLANY

DR. HARVEY ELECTED PRESIDENT OF THE ASSOCIATION OF YALE ALUMNI IN MEDICINE

At the annual meeting of the Association of the Yale Alumni in Medicine Dr. Samuel C. Harvey was elected President. Dr. Harvey has held the position of Professor of Surgery at the Yale School of Medicine for several years.

THE RABIES DANGER

Dr. Myron H. Davis of the Saugus Board of Health has asked the Selectmen to issue an order for the restraint of dogs in that town. An unusual number of dog-bite cases have been reported in that section of the state and two deaths apparently caused by rabies have occurred. The second case will be studied by the pathologist at the Boston Children's Hospital in order to determine whether death was due to rabies.

THE BOSTON FLOATING HOSPITAL HAS A DEFICIT

The report of the Boston Floating Hospital for 1933 presents the following facts: 13,049 days of care, 1370 new patients, 938 operations, and 1111 visits made by the field nurse. The total income was $75,219.30 with a total expense of $79,346.70, thus leaving a deficit of $4,127.40. This deficit must be raised by contributions and merits a generous response.

This is one of the important charities of interest to Boston.

UNNECESSARY DEATHS

According to the *New York Times*, Health Commissioner Parran has said that of the yearly toll of one hundred and fifty thousand deaths in New York State, more than fifty thousand die for lack of adequate medical treatment.

This spectacular statement is too indefinite to warrant more than a question as to whether the Commissioner has facts at his disposal to sustain this alarming claim.

It is, however, generally believed that a great many lives are being needlessly sacrificed, but we dislike to think that medical service is denied to so large a number, and if so the contributory factor may be in large measure due to the ignorance and prejudice of these people who procrastinate or worship false gods. It cannot all be laid to the medical profession. One does not see the remedy for the great mortality until the facts are shown. It would seem probable that enlightenment of the masses would accomplish some good, and setting the medical profession at work to find ways to supply needed treatment is indicated. If state medicine is required to meet this challenge, even that is a lesser disquieting procedure than this great human loss.

If the profession cannot cope with this problem, the people will, and if the electorate gets aroused, there may be swift and unwise action.

RÉSUMÉ OF COMMUNICABLE DISEASES IN MASSACHUSETTS FOR MAY, 1934

Lobar pneumonia and pulmonary tuberculosis show a slight increase over last year's figure.

The unusually high incidence of measles of the past few months is definitely subsiding.

Typhoid fever and diphtheria continue to be reported in diminishing figures.

Anterior poliomyelitis, epidemic cerebrospinal meningitis, chicken pox, mumps, German measles, scarlet fever, and tuberculosis other forms show nothing remarkable.

Whooping cough and dog bite show considerable increase over the corresponding month of last year.

RARE DISEASES

Anterior poliomyelitis was reported from Cambridge, 1; Quincy, 1; Walpole, 1; Wrentham, 1; total, 4.

Dysentery (amebic) was reported from Worcester, 3.

Dysentery (bacillary) was reported from Boston, 2.

Encephalitis lethargica was reported from Boston, 1; Clinton, 1; Deerfield, 1; total, 3.

Epidemic cerebrospinal meningitis was reported from Boston, 2; Northampton, 1; Peabody, 1; total, 4.

Malaria was reported from Cohasset, 1; Taunton, 1; total, 2.

Pellagra was reported from Boston, 1.

Septic sore throat was reported from Boston, 9; Fall River, 1; Montague, 1; Petersham, 4; Quincy, 1; Southwick, 1; Wellesley, 1; Westfield, 12; Weymouth, 1; total, 31.

Trachoma was reported from Cambridge, 1; Lawrence, 1; Malden, 1; total, 3.

Trichinosis was reported from Boston, 2.

Typhoid fever was reported from Becket, 1; Boston, 5; Brookline, 1; Foxboro, 1; Worcester, 1; total, 9.

Undulant fever was reported from Amherst, 1; Marlboro, 1; Middleboro, 1; Newton, 1; Orange, 1; total, 5.

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

MONTHLY REPORT FOR MAY, 1934

Diseases	May 1934	May 1933	Average*
Anterior poliomyelitis	4	5	5
Chicken pox	993	1090	986
Diphtheria	45	86	184
Dog bite	843	712	648
Epidemic cerebrospinal meningitis	4	5	14
German measles	148	107	476
Gonorrhea	535	454	492
Lobar pneumonia	330	285	360
Measles	5724	2466	3653
Mumps	576	779	799
Scarlet fever	1007	1521	1395
Syphilis	405	422	334
Tuberculosis pulmonary	354	338	387
Tuberculosis other forms	39	55	56
Typhoid fever	9	14	18
Undulant fever	5	1	—
Whooping cough	1318	710	814

*Average number of cases for May during the preceding five years.

A REPORT OF THE MILBANK MEMORIAL FUND

The number of physicians' calls to sick working people was cut by one-sixth during the period 1929 to 1933, while the percentage of illnesses hospitalized increased considerably during the same period, and the amount of free care both from hospitals and physicians soared to a very high point, according to a first-hand census to determine the relation between sickness and the depression made jointly by the United States Public Health Service and the Milbank Memorial Fund.

The report presenting these comparisons has been drawn up by G. St.J. Perrott and Selwyn D. Collins, of the Public Health Service, and Edgar Sydenstricker, director of public health activities of the Milbank Memorial Fund. It is one of a series of reports several of which have already been made public.

The survey consisted of a house-to-house canvass of 6,686 wage-earning families comprising 29,000 individuals, residing in Baltimore, Birmingham, Cleveland, Detroit, New York, Pittsburgh, and Syracuse. After the investigators had turned in their findings, the families were classified into three groups, namely, "Poor," comprising those with annual incomes averaging less than $150 per person; "moderate," those with $150 to $424 per person; and "comfortable," those with $425 or more per person per year. Families with downward shifts in income since 1929 from one class to another were compared with families who experienced no loss of income. As a check these results were also compared with findings for families in similar income levels by the Committee on the Costs of Medical Care for the period 1928-1931, and it is indicated that only about 52 per cent of the cases of illness received some medical care, whether from doctor or hospital, in 1933 as against 68 per cent in 1928-1931, the difference amounting to a drop of 23½ per cent. However, hospitalization taken by itself showed a rise of about 14 per cent for this period, being given to about 7.4 per cent of the illnesses in 1933 as against 6½ per cent in 1928-1931.

Figuring on the basis of physicians' calls per thousand persons (whether sick or not), the survey shows nearly 11 per cent fewer calls in 1933 for all the families questioned than would presumably have been the case if none of them had experienced a loss of income since 1929. In other words, this is the drop in doctors' care as shown by comparing the families whose incomes dropped with those who remained on their respective wage levels. But the sickness rate among families with reduced incomes was higher than that of the families not suffering loss of income and this brought a need for more physicians' care. When this fact is taken into account, the physicians' calls actually made were 17 per cent fewer than would have been expected if the ability to purchase medical care had not been lowered. Nearly 29 per cent more hospital care per thousand persons (whether sick or not) was shown in 1933 than would have been the case if all the families had continued without reduction of income.

Along with the cut in general medical care and the increase in hospitalization went increases in the amount of free care obtained. The comparisons reveal that the families investigated in the seven cities received 49 per cent more free hospital care than they would have received if there had been no depression. About 15 per cent more free care was obtained from physicians.

An interesting fact revealed by the survey was that families whose incomes had been in the "poor" class since before 1929 got considerably more free care than the wage-earning families who had

dropped from higher income levels. Thus the wage-earners who remained "poor" paid for only 24 per cent of the calls made by doctors, while those who had dropped from the "moderate" group to the "poor" group paid for 42 per cent of the calls received, and those who had been "comfortable" but are now "poor" paid for a still higher proportion, 46 per cent, of the doctors' calls which they received. Taking the "new poor" and the "chronic poor" all together, it was found that 61 per cent of the calls made by physicians were free to the families.

There were more acute disabling illnesses in the "poor" class than in the "comfortable" class, the rate for the former being 108 cases per 1,000 persons, or slightly more than one in ten, as against a corresponding figure of 80 per 1,000 persons in the "comfortable" class. However, the "poor" received only 2.2 calls per illness from doctors as compared with 3.7 calls for the "comfortable". This difference in physicians' care presumably arose through better ability to pay on the part of those with the higher incomes. The "poor," however, received more hospital care per case and more care from visiting nurses than those rated as "comfortable".

COMPARISON OF DISEASE INCIDENCE IN CONNECTICUT WITH 1933 AND SEVEN YEAR AVERAGE

MONTH ENDING MAY 26, 1934

Diseases	1934 Week ending May 5	1934 Week ending May 12	1934 Week ending May 19	1934 Week ending May 26	Average cases reported for week corresponding to May 26 for past seven years	1933 Week ending May 6	1933 Week ending May 13	1933 Week ending May 20	1933 Week ending May 27
Cerebrospinal Men.	—	—	1	3	1	—	—	1	1
Chicken Pox	82	162	135	122	110	132	196	184	189
Conjunctivitis Inf.	4	4	1	—	3	—	—	—	—
Diphtheria	3	2	3	—	14	1	—	5	2
Dysentery Bacillary	—	—	—	—	—	1	—	—	4
Encephalitis Epid.	—	—	2	—	—	—	—	—	—
German Measles	11	2	3	14	41	12	15	15	15
Influenza	1	—	1	1	8	4	4	3	2
Measles	126	90	156	173	235	274	305	281	226
Mumps	65	121	64	140	75	73	90	63	93
Paratyphoid Fever	2	—	—	—	—	—	—	—	1
Pneumonia (Broncho)	22	19	23	16	26	14	14	9	17
Pneumonia (Lobar)	27	39	30	32	34	28	21	21	28
Poliomyelitis	—	1	—	—	—	—	—	—	—
Scarlet Fever	60	70	59	57	100	106	113	112	85
Septic Sore Throat	4	3	4	—	1	3	1	2	1
Smallpox	—	—	—	—	—	—	—	—	2
Tetanus	—	1	1	—	—	—	—	—	—
Trachoma	—	—	1	—	—	2	—	—	—
Trichinosis	—	—	—	1	—	1	—	—	—
Tuberculosis (Pul.)	25	42	14	38	24	37	36	23	19
Tuberculosis (O. F.)	4	2	—	4	3	2	3	1	3
Typhoid Fever	1	—	1	1	—	3	1	3	1
Undulant Fever	3	1	2	1	—	1	—	—	—
Whooping Cough	59	57	35	60	57	66	60	50	50
Gonorrhea	23	20	23	28	38	38	54	25	41
Syphilis	64	42	40	44	37	26	41	42	35

Remarks: No cases of Asiatic cholera, glanders, plague or yellow fever during the past seven years.

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

DIVISION OF ADULT HYGIENE

Number 14 *Cancer Clinic Bulletin* June 1, 1934

NOTES:

The material presented in this month's bulletin represents the author's own conclusions regarding the subject of his article, Radiosensitivity of Tumors which first appeared in the *Archives of Surgery*, December, 1933.

The article has been made easily available in monograph form. Copies may be obtained (price twenty-five cents) by addressing the American Society for the Control of Cancer, 1250 Sixth Avenue, New York City.

RADIOSENSITIVITY OF TUMORS

BY FRED W. STEWART, M.D.

Conclusions of the Author:

"My purpose has been to emphasize the complexity of the problem of radiosensitivity. I have called attention to the difficulties of establishing hard and fast rules. I have encouraged the notion that ideas of tumor sensitivity may change with changes in radiologic technic. I have called attention to the need of expressing response to radiation in terms of dosage. Peculiarities in the behavior of certain tumor types have been noted, and differences in the responses of apparently similar tumors in different regions have been discussed. Much of the paper has unfortunately been devoted to the statement of observed facts, which are wholly unexplained. It is difficult to summarise in a few sentences material which many pages have but incompletely described, yet since some crystallization is necessary, the following brief paragraphs may serve.

"1. Radiology is an active science. Ideas and methods are constantly changing. As methods change, notions of what may be expected from irradiation of tumors will also change. For example, if current ideas of radiosensitivity were derived wholly from observations made in the days when the low voltage x-rays represented the entire therapeutic armamentarium, then sensitive tumors would be rare and the field of radiology limited. Improved methods, while they alter no fundamental principles, constantly widen their applicability to the advantage of the patient with cancer.

"2. Radiosensitivity may mean rapid tumor regression, slower progressive regressions over a period of from days to weeks or slow chronic atrophy requiring months or perhaps a year for completion. Of course, the same mechanisms are not responsible for these various responses, nor do they occur in the same types of tumors. Radiosensitivity does not mean the certainty of cure by irradiation, nor does radioresistance imply that a given tumor is not curable by irradiation.

"3. Certain tumors seem to possess inherent properties of radioresistance, as witnessed, for example, in the melanomas and neurogenic tumors.

"4. Radiosensitivity increases with increasing embryonal quality of the tumor cells. By embryonal quality I do not imply that all tumors of embryonal origin are equally radiosensitive, since embryonal quality I do not imply that all tumors of embryonal tumors rapidly acquire adult characteristics, for example, the complex teratomas.

"5. Radiosensitivity increases with the increasing degree of anaplasia. This rule is subject to interpretation, for not all anaplastic tumors are radiosensitive. Some are highly resistant, and unless the exact type of anaplastic tumor is specified, anaplasia may be of little significance.

"6. Radiosensitivity is always a relative property. When one states that a carcinoma of the breast, for example, is radiosensitive, one should imply that it is sensitive according to the accustomed scale of behavior of tumors of the breast and not according to the same scale of sensitivity one applies to lymphosarcoma.

"7. Tumors are apt to be more sensitive in young subjects. An anemic or cachectic person is a poor subject for radiation.

"8. Infection interferes with a normal response to radiation.

"9. Desmoplastic tumors are apt to be radioresistant.

"10. The tumor bed is of great importance. A normal tumor bed is generally favorable. Bone, cartilage and fat make unfavorable mediums for reactive processes and hence for regression of the tumor. An avascular bed is unfavorable for response to radiation.

"11. Tumors, when metastatic to lymph nodes, may be more or less sensitive than the primary tumors. This phenomenon is not fully explained. Metastases to the lymph nodes, long established, tend to be less sensitive than recent emboli. The old metastasis has had time to acquire its definitive blood supply and to adapt itself to its new surroundings, while the recent embolus is still foreign to its new soil. A recent, rapidly growing metastasis is more apt to be unstable than a smaller metastasis of longer duration. Cystic nodes are apt to be resistant.

"12. Bulky tumors may become resistant after infarction and liquefaction, even though they belong to the usually sensitive types. This may be due to the fact that fibrosis proceeds slowly and inefficiently under such conditions. The cells in the liquefied areas are removed from restraining fibrosis. The same explanation may be applied to the resistance of tumor cells lying in the midst of degenerative or secretory mucin, for example in gelatinous carcinomas, mucinous ovarian adenocystomas, degenerating chondroblastic tumors or Schneiderian cancer with an overproduction of mucus. Secretion, however, is the expression of the assumption of adult character in a tumor cell and hence must supposedly render it more resistant.

"13. The anatomic characteristics are of decided

importance. Among these may be mentioned the papillary character, delicacy of the blood supply and enclosure within a firm capsule, which may result in the obliteration of circulation after irradiation has caused the tumor to become edematous. Diffuse lymphatic plugging by tumor cells may lead to edema and interference with cell-fluid exchanges.

"14. In the case of certain tumors some unknown physiologic mechanism seems involved in the response to radiation. Examples of this appear in myoma uteri and carcinomas of the breast, ovary and thyroid.

"15. The effect of radiation is always complex. It involves not only the tumor cell, but the tissues of the host, and possibly general reactions on the part of the host. The ultimate effect of the radiation must always result from a nice balance between tumor effect and response of the host tissue.

The relative importance of the two mechanisms varies in different tumors. In some instances the known sensitivity is such that the radiologist may endeavor to destroy the tumor cells. In others he can but hope for restraint of growth by moderately affecting the tumor cell and trusting that the responses of the host tissue will play a decided rôle. Under such circumstances tumor cells may remain in an indolent state in the midst of fibrous tissue for many years without giving rise to further damage.

"16. Unfortunately, more particularly in the case of the extremely sensitive tumors, the radiologist is apt to be so impressed with the initial regression of the disease that he fails to push his treatment to tolerance and waits until, after a period of quiescence, the disease recurs in a more resistant form, when he must essay to do under poorer conditions what he failed to do at the start."

HISTORICAL SKETCHES ON PUBLIC HEALTH PREPARED FOR THE MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH AND SPONSORED BY THE MASSACHUSETTS MEDICAL SOCIETY

Vaccination of Today

BY ELEANOR J. MACDONALD, A.B.*

It is hard for those of us who live in such a community as is the Massachusetts of to-day, to imagine the havoc wrought by smallpox in the past. This disease, which in its virulent form may kill as high as one out of every four that it attacks, exerted a tremendous influence on the civilization of former centuries. So rarely did a person escape the disease that it was said, with some justice, that no one should count a family until all of the children had had smallpox. Lord Macaulay, in his History of England, writing of the time of William and Mary, makes this interesting comment: "That disease, over which science has since achieved a succession of glorious and beneficent victories, was then the most terrible of all the ministers of death. The havoc of the plague had been far more rapid: but the plague had visited our shores only once or twice within living memory: and the smallpox was always present, filling the churchyard with corpses, tormenting with constant fears all whom it had not yet stricken, leaving on those whose lives it spared the hideous traces of its power, turning the babe into a changeling at which the mother shuddered, and making the eyes and cheeks of the betrothed maiden objects of horror to the lover."

In 1720, in Boston, 10 per cent of the population was killed by smallpox in one year. In 1933 there was not a single case of smallpox in Massachusetts. The intervening history has contained much that was detrimental and deterrent to the present state of smallpox. At first those who opposed vaccination had grotesque pictures displayed portraying the development of horns and hoofs on those who had submitted. These pictures appeared not in jest, but as the sincere convictions of those who foresaw in vaccination all sorts of imaginary dangers. Time has shown the fallacy of such notions, yet many of the quotations being used today as arguments against vaccination originated in this epoch.

The vaccinations that were performed in the troublous times of Dr. Waterhouse were made directly from the arm of one person to the arm of another. Those were the days before we had acquired our present-day knowledge of aseptic precautions. With such a procedure of transfer from one person to another, commonly without adequate knowledge of the disease or even several diseases from which the original person might be suffering, it was to be expected that occasional ill effects should occur. Sanitary precautions were ignored in the various steps leading to and including vaccination. The fear of smallpox was so great that frequently the doctor was not content with a single vaccination, but applied several in different parts of the body to insure a higher level of resistance.

During the second half of the last century and especially during the twentieth century there have been great strides made in the method of vaccination. The development of our knowledge of bacteriology and the discoveries resulting from the scientific studies made of the subject are responsible for this. No longer is the vaccine introduced directly from the arm of one person to the arm of another. All the material is carefully produced in well-supervised laboratories under precautions which would do credit to the operating room of any hospital. The material is carefully tested and standardized, and before release is further tested by the Federal Government. It is placed in sealed tubes under the most careful precautions, and these tubes are kept sealed until opened by the physician who is to vaccinate. No longer do we see the severe and usually painful scratching at the point where the vaccine is to be

*Statistician, Division of Adult Hygiene, Massachusetts Department of Public Health.

introduced. A successful vaccination can be performed by so slight a pricking of the skin with a sterile needle as not even to draw blood.

From the foregoing account of vaccination to-day and yesterday one can see how manifestly unfair it is to compare them,—and yet, much of the opposition does originate from an exclusive consideration of the earlier type of vaccination.

The results of vaccination have been so striking that they need little, if any, comment. Massachusetts, which enjoys the protection of a law requiring vaccination of children attending the public schools, has the lowest smallpox rate of any state in the Union. Those states that do not have compulsory vaccination have from twenty to two hundred cases of smallpox for every case that occurs in Massachusetts.

A group of states which have laws that forbid compulsory vaccination have 115 cases of smallpox for every case that Massachusetts has, and yet there are those who, like the fear-ridden or uninformed of the eighteenth century, would amend our laws and place us in the position of having 115 times as much smallpox as we now have. This they do while impugning the integrity of those who defend vaccination on its proved merits. This they do by defaming those who have given so unsparingly of their time and energies to the perfection of this life-saving procedure, and to support their arguments they quote from the untoward results leading to the comparatively few deaths from inoculation in the past centuries. Just so long as Massachusetts continues to enjoy compulsory vaccination will it also enjoy its freedom from smallpox. If, however, the compulsory vaccination law is withdrawn, then the penalty of increased suffering and death from smallpox, now the lot of other states who have followed false prophets, will become the lot of Massachusetts. It is unlikely that such a condition will ever exist here, however. Because in spite of the vigorous propaganda carried on by the opponents of scientific medicine, the public at large realizes today the debt of gratitude that it owes to Dr. Jenner and respects his memory for the contribution that he made.

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CORRESPONDENCE

POSTGRADUATE COURSES

TUFTS COLLEGE MEDICAL SCHOOL

416 Huntington Avenue, Boston, Mass.

Office of the Dean, June 21, 1934.

Editor, *New England Journal of Medicine.*

Inquiries from our graduates have prompted us to consider the offering of postgraduate courses to physicians. A course in Internal Medicine for General Practitioners has already been announced in your advertising columns. This course will be given during July at the Beth Israel Hospital. The tuition fee is fifty dollars. Further information regarding it may be had by applying to Dr. Harry Linenthal, Physician-in-Chief of the Beth Israel Hospital.

Similar courses may be made available at the Boston Dispensary and the Boston City Hospital during August if applicants therefor are interested. It is possible that many of the clinical facilities of Tufts Medical School could be placed at the disposal of practicing physicians in New England, and it is the desire of the School to thus utilize them whenever suitable.

I hope you can call this to the attention of your readers. Physicians interested may communicate with the Committee on Postgraduate Courses at Tufts College Medical School, 416 Huntington Avenue, Boston, Massachusetts.

Very truly yours,

A. WARREN STEARNS, M.D., *Dean.*

PRE-PARALYTIC INFANTILE PARALYSIS SERVICE

THE COMMONWEALTH OF MASSACHUSETTS

Department of Public Health

State House, Boston, June 20, 1934.

Editor, *New England Journal of Medicine.*

May I announce through your columns that beginning July 1, 1934 the Department will resume twenty-four hour telephone service to enable physicians to obtain consultant service in cases of suspected pre-paralytic infantile paralysis. All calls during office hours should be made directly to the State House, Capitol 4600; at other hours all such calls will be handled through Kenmore 8100.

It is the purpose of this consultant service to assist physicians in suspected pre-paralytic cases in which serum treatment may depend upon prompt diagnosis. The Department, cannot, however, offer any such service in paralyzed cases and will be forced to refuse to send a consultant in such instances. As for the past two years, serum may be obtained directly from certain local hospitals, providing a lumbar puncture has already been performed and examination of the fluid shows indications of infantile paralysis.

Very truly yours,

HENRY D. CHADWICK, M.D.,
Commissioner of Public Health.

THE AMERICAN NEISSERIAN MEDICAL SOCIETY

Boston, June 20, 1934.

Editor, *New England Journal of Medicine.*

A group of physicians from various sections of the country met together at Cleveland, Ohio, on June 12, 1934, and formed an organization for the purpose of doing, on a national scale, the work

started in 1930 by the Neisserian Medical Society of Massachusetts. The name of the organization is the American Neisserian Medical Society.

The following officers were elected: Dr. J. Dellinger Barney of Boston, president, Dr. P. S. Pelouze of Philadelphia, vice-president and the undersigned, secretary.

Membership is limited to urologists and gynecologists especially interested in, and who desire to work for improvement in, the management of gonorrhea.

The Massachusetts Society will continue to function as an independent organization but will coöperate in every possible way with the National Society.

Very truly yours,
OSCAR F. COX, JR., M.D.

THE PERIODIC HEALTH EXAMINATION

Editor, *New England Journal of Medicine*,

Having been interested for some years in the principle of periodic health examinations and having come to believe that the principle is sound, I read with interest the opinions published on this subject by the Committee on Public Health of the Massachusetts Medical Society*. The Committee says, in its concluding paragraph, that ". . . . universal investigation of recently acquired trivial signs and symptoms by the family doctor would be more profitable than the periodic health examination. . . . ."

This may be true, but the proposal has serious disadvantages. First, few actively occupied persons can be induced to consult a physician for symptoms which, to them, appear trivial. Secondly, those having neurotic tendencies would inevitably be stimulated to watch their symptoms still more closely and, finally, if the plan were followed generally, much additional expense would be incurred for needless visits to the physicians.

On the other hand, it is certainly the duty of the family physician in the present and in the future to do far more toward the promotion of *health in the positive* sense and toward the prevention of disease than has been customary in the past. The periodic examination conducted intelligently by the family physician, who knows the background of the patient's life and who understands his personality, should offer valuable opportunities which would otherwise be missed. For example, dangerous diseases such as pulmonary tuberculosis, incipient circulatory weakness, ulcer of the stomach and cancer might be detected earlier. Maladjustments, too, which have begun to cause neurosis or which are laying the foundation for a nervous breakdown could be promptly recognized, and persons of middle age should be cautioned about overweight. These are but a few examples of what might be accomplished. I believe that periodic examinations made by the family physician are more likely to be useful than those performed by persons who do not really know the people whom they examine.

No plan of medical supervision that can be devised now, will detect all cases of internal cancer in an early stage or prevent certain other dangerous diseases which we do not know how to prevent. But, should the periodic examination, therefore, be condemned?

Most of us have long since become accustomed to see our dentist frequently in order that small cavities may receive prompt attention. The practice is becoming general of consulting the pediatrist about the growing child, even when all seems well with it. Moreover, public school children are being examined at regular intervals and many universities have undertaken periodic examinations of their student body. If these things are worth while, should we not continue to make medical check-ups during the later years of adult life? There is no period of life during which health may not be jeopardized. The active working years bring increased responsibility for the welfare of others, and render positive health of the greatest importance. Is this the time to give up medical supervision?

As for the examination itself, a simple routine should be carried through at every examination, and this need be supplemented only when there are indications for so doing. The expense to the patient would then, usually, be small. For those who have shown no serious signs or symptoms, an annual examination would be reasonably adequate. The physician, however, should use his best judgment in every case, and should advise certain patients to return at shorter intervals.

The periodic examination has certain great advantages for the patient. It enables him, without loss of self-respect, to consult his physician about apparently trivial symptoms of which he would be ashamed to complain, and the advice given should, frequently, enable him to improve his health and thus to increase his efficiency and enjoyment of life.

Should the principle of the periodic examination receive general acceptance by the medical profession, it would become necessary to convince the public of the value of this procedure. The public should be told the limitations as well as the advantages of the plan, but, should organized medicine undertake to initiate the plan, it would lay itself open to the suspicion of advocating it to "increase business." For the same reason, it might at first be embarrassing for the family physician to advocate periodic examinations. Therefore, the potential value of the periodic examination should first be explained to the public by official health agencies and by lay groups which are interested in the promotion of health. Medical societies and physicians who believe in the value of such examinations should then help to popularize the movement.

GEORGE CHEEVER SHATTUCK, M.D.

*The Periodic Health Examination. NEW ENG. J. MED. 210: 226-230 (Jan. 25) 1934.

MORBIDITY REPORT OF VENEREAL DISEASES

TREASURY DEPARTMENT, PUBLIC HEALTH SERVICE,
WASHINGTON

June 12, 1934.

Managing Editor, *New England Journal of Medicine*,

Your attention is invited to the accompanying morbidity report of the venereal diseases for the month of April, 1934. This statement is prepared monthly by the Public Health Service and, because of the widespread prevalence of the venereal diseases, is of much importance to physicians and other individuals interested in the prevention and eradication of syphilis and gonorrhea. It is possible that you may find this statement of sufficient significance to publish it in your *Journal* regularly. A copy will be mailed to you in the future each month.

It is hoped that by releasing this statement, the Public Health Service may assist the State and local boards of health in interesting the individual physicians of the United States in the more thorough reporting of the venereal diseases. The present trend is to neglect the submission of such morbidity reports, yet the extensiveness of venereal disease prevalence can never be ascertained without the thorough coöperation and assistance of all of the physicians of the country. It is hoped that the publication of the morbidity reports by States may stimulate a spirit of friendly rivalry among physicians and health officers responsible for this activity.

Respectfully,

H. S. CUMMING, *Surgeon General.*

The appended report presents the statistical evidence.

HEALTH OFFICERS' MONTHLY STATEMENT OF VENEREAL DISEASES REPORTED

April, 1934

This statement is issued monthly for the information of health officers in order to furnish current data as to the prevalence of the venereal diseases. The following reports were received from State Health Officers. The figures are preliminary and subject to correction. It is hoped that this will stimulate more complete reporting of these diseases.

State	Syphilis		Gonorrhea	
	Cases reported during month	Monthly case rates per 10,000 population	Cases reported during month	Monthly case rates per 10,000 population
Alabama	320	1.19	85	0.32
Arizona	22	.49	131	2.89
Arkansas	537	2.87	221	1.18
California (b)				
Colorado (a)	—	—	—	—
Connecticut (c)	224	1.36	96	.58
Delaware	90	3.73	52	2.16
Dist. of Columbia	148	2.99	89	1.80
Florida	302	1.94	50	.32
Georgia	563	1.93	337	1.16
Idaho	0	—	0	—
Illinois	1894	2.42	1293	1.65
Indiana	146	.44	130	.40
Iowa (c)	117	.47	131	.53
Kansas	129	.68	63	.33
Kentucky	192	.73	303	1.14
Louisiana	209	.97	136	.63
Maine	42	.52	49	.61
Maryland	663	3.99	263	1.58
Massachusetts	389	.90	431	1.00
Michigan	483	.96	344	.68
Minnesota	379	1.46	304	1.17
Mississippi	1056	5.16	1501	7.33
Missouri	623	1.70	300	.82
Montana (c)	52	.97	13	.24
Nebraska	43	.31	57	.41
Nevada (a)	—	—	—	—
New Hampshire	14	.30	14	.30
New Jersey	691	1.65	219	.52
New Mexico	76	1.75	25	.58
New York	4855	3.74	1139	.88
No. Carolina	987	3.01	280	.85
North Dakota	27	.39	40	.58
Ohio (c)	599	.88	229	.34
Oklahoma (c)	134	.64	101	.48
Oregon	19	.19	59	.60
Pennsylvania (b)				
Rhode Island	45	.64	47	.67
So. Carolina (c)	403	2.31	502	2.87
South Dakota	2	.03	17	.24
Tennessee	1180	4.43	431	1.62
Texas	153	.25	27	.04
Utah (a)	—	—	—	—
Vermont	19	.53	18	.50
Virginia	357	1.46	233	.95
Washington	160	1.00	194	1.21
West Virginia (b)	—	—	—	—
Wisconsin (d)	33	.11	157	.52
Wyoming (a)	—	—	—	—
Total	18377	1.74	10111	0.96

(a) Not reporting.

(b) Have been reporting regularly but no report received for current month.

(c) Incomplete.

(d) Only cases of syphilis in the infectious stage are reported.

Surveys in which all medical sources have been contacted in representative communities throughout the United States have revealed that the monthly rate per 10,000 population is 6.6 for syphilis and 10.2 for gonorrhea.

ARTICLES ACCEPTED BY THE AMERICAN MEDICAL ASSOCIATION COUNCIL ON PHARMACY AND CHEMISTRY

535 North Dearborn Street, Chicago, Ill.,
May 31, 1934.

Managing Editor,

The *New England Journal of Medicine*,

Dear Doctor:

In addition to the articles enumerated in our letter of April 30 the following have been accepted:

Bilhuber-Knoll Corporation
Dilaudid
Ampules Solution Dilaudid, 2 mg. (1/32 grain), 1.1 cc.
Hypodermic Tablets Dilaudid, 2 mg. (1/32 grain)
Hypodermic Tablets Dilaudid, 3.2 mg. (1/20 grain)
Hypodermic Tablets Dilaudid, 4 mg. (1/16 grain)
Tablets Dilaudid, 2.5 mg. (1/24 grain)

H. E. Dubin Laboratories, Inc.
Aminophyllin—Dubin
Ampules Solution Aminophyllin—Dubin, 0.24 Gm., 10 cc.
Ampules Solution Aminophyllin—Dubin, 0.48 Gm., 2 cc.
Suppositories Aminophyllin — Dubin, 0.36 Gm.
Tablets Aminophyllin—Dubin, 0.1 Gm.

Gilliland Laboratories, Inc.
Diphtheria Toxoid, Alum Precipitated (Refined)

Schering & Glatz, Inc.
Medinal
Medinal Tablets, 5 grs.
Medinal Suppositories, 10 grs.

Frederick Stearns & Co.
Neo-Synephrin Hydrochloride
Solution Neo-Synephrin Hydrochloride, 0.25 Per Cent
Solution Neo-Synephrin Hydrochloride, 1 Per Cent

Winthrop Chemical Co., Inc.
Chiniofon—Winthrop
Tablets Chiniofon — Winthrop, 0.25 Gm. (4 grains)

The following product has been accepted for inclusion in the List of Articles and Brands Accepted by the Council But Not Described in N.N.R. (New and Nonofficial Remedies, 1934, p. 443):

Cheplin Biological Laboratories, Inc.
Cheplin's Epinephrine Hydrochloride Solution 1:1000 Ampules 1 cc.

Yours sincerely,

PAUL NICHOLAS LEECH, *Secretary*,
Council on Pharmacy and Chemistry.

OBITUARY

DR. ABNER POST

1844—1934

Abner Post was born in Westfield, Massachusetts, August 9, 1844. He died in Cambridge, Massachusetts, April 20, 1934. At the age of twelve his father died and the boy, with his mother, went to live with her father. Those early years, spent in his grandfather's household, made a lasting impression on his character.

He prepared for College at Williston Academy, and graduated from Yale in 1866, and received his M.D. from Harvard four years later. He served as a surgical house pupil at the Massachusetts General Hospital under Doctors Richard Manning Hodges and Henry J. Bigelow. He studied abroad for two years, mostly in Vienna, and on his return to Boston entered the U. S. Marine Hospital at Chelsea, where he gained a wide experience in the treatment of venereal diseases, as well as general medical and surgical work.

In 1876 he was appointed to the Staff of the Boston Dispensary and continued on active duty there until he retired December 31, 1913.

Dr. Post had great interest in Surgery and would doubtless have devoted his life to this field had he not yielded to the influence of Dr. Francis B. Greenough, a dermatologist and syphilographer of note with whom he became associated at the Dispensary, and who revived his interest in syphilis. In consequence he gave up his position as surgeon at the Children's Hospital, which he had held for six years.

Dr. Post enjoyed clinical teaching and his service at the Dispensary gave him a large and varied amount of material for his demonstrations of syphilis. There are doubtless many who now remember his twelve o'clock clinic in the old building at the Dispensary. He always cautioned against overlooking extragenital non-venereal infections of syphilis, and emphasized the importance of early recognition of such conditions.

He was greatly interested in children with congenital syphilis. This led him to study and record syphilitic families at a time when many doctors were simply treating the individual patient, without attempting to ascertain whether other members of the family had become infected.

Dr. Post was one of the first to make use of the x-ray in studying syphilis of bones, joints and lungs. He was an early advocate of the use of arsphenamine in the treatment of pregnant syphilitic women and their offspring.

His interest in the early diagnosis and treatment of interstitial keratitis and symmetrical synovitis did much to conserve the eyesight and improve the health of these unfortunate children.

Dr. Post began teaching in the Harvard Medical School in 1882 and continued until 1916, when he resigned as Professor of Syphilis and became an

Emeritus. At the time of his death, he was the oldest member of the Harvard Faculty.

In 1882 he was appointed on the Surgical Staff of the Boston City Hospital and rose to the rank of Senior Visiting Surgeon in 1897, resigning in 1906. As a surgeon he was resourceful, skillful and conservative. The good of the patient was always his objective. If unusual conditions demanded original procedures, his courage was never lacking. He performed oesophagotomy on a child for the removal of a silver twenty-five cent piece. The operation was successful.

In 1884, while Surgeon to Out-Patients, Dr. Post performed the first *successful* "bloodless operation" for the congenital dislocation of the hip joint. The patient was a girl of seven years. Recovery was complete, after wearing a plaster of Paris cast for about seven months, and the patient walked without a limp. It was nearly twenty years later that so much publicity was given Professor Lorenz, of Vienna, when he carried out the same procedure on a little girl in New York City.

Dr. Post took great interest in the training and welfare of his internes. He was at his best in teaching small groups. In 1894 he began the Thursday evening clinical meetings, held monthly for the Staff and former internes. This was one of the earliest, if not the beginning of such hospital meetings. For several years he gracefully presided at these carefully arranged and well-attended exercises. In 1907 he was appointed honorary consulting surgeon which position he held at the time of his death.

He was appointed Consulting Physician in Syphilis at the Massachusetts General Hospital and for two years continued to teach Harvard Medical students in the newly created department for the care of all forms of syphilis. In this clinic, he and the late Dr. George S. Derby studied the effect of arsphenamine treatment of interstitial keratitis as measured by vision tests. Dr. Derby reported the results and conclusions on this group of cases in an article published in the *Ophthalmic Record* in 1917.

Dr. Post was an Associate Editor of the *Boston Medical and Surgical Journal* from 1881 to 1890. His principal contributions to medical literature were in the fields of Surgery and Syphilology. His papers were carefully prepared, concise and convincing. He felt very strongly that, from a medical standpoint, syphilis should be looked upon as a chronic contagious disease rather than as a sex problem or social disease and should be treated as such.

As a public health measure he endeavored to locate, if possible, the source of infection and subsequent contacts and bring them under treatment. He was one of the first to appreciate the value of a social service worker in the clinic.

Dr. Post's Clubs were the St. Botolph, Yale, Harvard and the Old University Club.

His membership in medical societies included the American Dermatological Association (of which he was one time president), American Medical Association, American Urological Association, Massachusetts Medical Society, New England Dermatological Society and other local medical societies.

He was a lover of nature, of flowers and of animals and for many years spent long seasons at his farm in Weston, Massachusetts. When he retired from practice, he made his winter home in Cambridge. In spite of physical infirmities, incident to age, he retained his mental vigor, enabling him to enjoy his family, his friends and his books until within a short time of his death.

RECENT DEATHS

DROWN- Miss Lucy Lincoln Drown, who served the Boston City Hospital first as a nurse, and later as Superintendent of Nurses for more than twenty-five years, died in Lowell, Massachusetts, June 22, 1934.

She retired in 1910, and will be long remembered as an important factor in the development of the training school for nurses at the City Hospital.

HEALY—Daniel Laurence Healy, M.D., of Framingham, Massachusetts, died at his home June 21, 1934.

He was born in Somerville in 1872, was educated at Boston College, and graduated in medicine from the Harvard University Medical School in 1898, and had practiced in Framingham since that date. He had served as school physician. He joined the Massachusetts Medical Society in 1901, and served on the staffs of the Framingham and Natick Hospitals.

He is survived by his widow, Katherine G. Healy, two sons, Daniel J. and James Healy, five brothers, and five sisters.

LYMAN—Henry Lyman, M.D., a retired physician, died in Ponkapoag, June 15, 1934. He was born in 1879, and graduated from the Harvard Medical School in 1912. He joined the Massachusetts Medical Society in 1914.

He was interested in farming, and was a member of many social clubs. He is survived by his widow, Elizabeth (Cabot) Lyman and three children.

NOTICE

CORRECTION

In our issue of June 14, page 1298, there appeared an item stating that Dr. Moses Kaufman had been elected to membership in the American Psychiatric Association at the meeting held in New York City in May, 1934. The item should have read that Dr. Kaufman had been elected to Fellowship, since he has been a member for five years.

SOCIETY MEETINGS, CONGRESSES AND CONFERENCES

July 24-31—The IVth International Congress of Radiology will be held in Zurich under the presidency of Professor H. R. Schnis. General Secretary Dr. H. E. Walther, Gloriastrasse 14, Zurich.

August 18 - September 20—Medical Study Trip to Hungary. See page 975, issue of May 10.

September 3-6—American Public Health Association, at Pasadena, California. Dr. J. D. Dunshee, Chairman, Local Committee on Arrangements.

September 4, 5, 6—International Union Against Tuberculosis. For information address the National Tuberculosis Association, 450 Seventh Avenue, New York City.

September 10, 11, 12, and 13—American Congress on Physical Therapy will meet in Philadelphia at the Bellevue Stratford. For details write American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago, Illinois.

September 10-15—First International Congress of Electro-Radio-Biology will be held in the Doges Palace at Venice. For details address the General Secretary of the Congress, Dr. Giocondo Protti, S. Gregorio 173, Venice (Italy).

September 27 and 28—International Association for Preventive Pediatrics will be held at Lyons. For details address the Secretary of the I. A. P. P., 15 rue Lévrier, Geneva (Switzerland).

September 28-29—New England Surgical Society will meet at Burlington, Vermont. For details address the Secretary, Dr. John M. Birnie, 14 Chestnut Street, Springfield, Mass.

October 22 - November 2—1934 Graduate Fortnight of the New York Academy of Medicine. See page 1240, issue of June 7.

October 31 - November 2—Massachusetts State Nurses' Association, Hotel Statler, Boston. For information write Miss Helene G. Lee, R.N., 420 Boylston Street, Boston.

April 29 - May 3, 1935—The American College of Physicians will meet in Philadelphia. For information address Mr. E. R. Loveland, Executive Secretary, 133-135 South 36th Street, Philadelphia, Pa.

June, 1935—Medical Library Association will meet in Rochester, N. Y. For details address the Secretary: Miss Frances N. A. Whitman, Librarian, Harvard University Schools of Medicine and Public Health, Boston, Mass.

BOOK REVIEWS

Aids to Pathological Technique. By David H. Haier. Students Aids Series. 187 pp. Baltimore: William Wood and Company. $1.50.

This small handbook of laboratory methods is concise; in fact, almost too concise to be of real service. For a quick review of laboratory subjects it has advantages. The methods recommended are somewhat different from those in common use in some of the laboratories in this country. In general it has more of the character of a sketchy quiz-compend than an adequate presentation of the subject and is certainly not to be recommended for the practitioner or laboratory worker.

Physiopathologie des Syndromes Endocriniens. By Noël Fiessinger. 312 pp. Paris: Masson et Cie. 40 fr.

The reviewer read this book several months ago and put it aside to reread because he thought he was in a bad humor. As a result the review is late.

This book is an interesting attempt to approach clinical medicine from the physiological aspect. This excellent approach, however, is injured by loose statements both in regard to the laboratory work and the clinic. One reads an interesting account of disease and then one comes upon a statement which is obviously questionable. The names of authors are frequently referred to but there are no references given in the book so that there is the aspect of authority but yet no way of confirming statements by original evidence. From the reviewer's point of view this is a great handicap. The book has the excellent French characteristic of good clinical descriptions.

Synopsis of Obstetrics and Gynecology. By Aleck W. Bourne. Fifth Edition. 439 pp. Baltimore: William Wood and Company. $5.25.

This book is fashioned after the manner of the quiz-compends that have been published in this country for some years. For a hurried review of the subject it may be satisfactory, but for any real student of obstetrics and gynecology this book is of no avail. It contains many statements with which American obstetricians do not agree, and much of the technique is not that which we follow in this country.

Aids to Qualitative Inorganic Analysis. By R. G. Austin. Students Aids Series. 204 pp. Baltimore: William Wood and Company. $1.50.

This miniature laboratory guide is apparently serviceable for the student of elementary chemistry. It is accurate so far as it goes, and may be useful for some one attempting to review chemistry for a basic science examination.

You Must Relax: A Practical Method of Reducing the Strains of Modern Living. By Edmund Jacobson. 201 pp. New York and London: Whittlesey House, McGraw-Hill Book Company. $1.50.

Some years ago this author wrote a more formal book on "Progressive Relaxation," which contained much of value in regard to the physiology of the neuromuscular mechanism. He has now attempted, with much less success, to write a small, popular treatise on the same condition, with the implication that muscular relaxation is a valuable adjunct to our therapy for conditions such as insomnia, colitis, and hypertension. While much of the theory behind this little book is correct, one feels that its value is likely to be over-emphasized by the average reader. We talk about the strain of modern living, but do we actually know how much this has to do with the psychoneuroses and hypertension? Is not the author basing his conclusions in regard to relaxation, as a practical method of reducing neuromuscular tension, on somewhat uncertain premises?

The Single Woman. A Medical Study in Sex Education. By Robert Latou Dickinson and Lura Beam. 469 pp. Baltimore: The William & Wilkins Company.

This book is the second volume of a series of case studies of which the first was entitled "A Thousand Marriages." With its avowed purpose—"an inquiry into the sex life of the single woman . . . . in the interests of sex education, particularly with a view to marriage"—your reviewer is in hearty accord. Whether this particular volume has accomplished its purpose and justified its publication is

open to considerable question. The general impression gained is of a mass of poorly digested and badly correlated data. This could perhaps be condoned were we satisfied that the case histories represent a fair cross section of the emotional life and experiences of normal unmarried women. It would seem, however, to be a foregone certainty that case histories from the practice of one man will not be able to fulfill these requirements. In spite of these evident shortcomings the whole could have been saved from seeming futility by some thread of critical interpretation. The question we ask ourselves is why this has not at least been attempted. The book may still have something of interest for the student of abnormal psychology, but offers little of value for the average medical man.

Wilhelm Conrad Röntgen and the Early History of the Roentgen Rays. By Otto Glasser, with a chapter by Margret Boveri. 494 pp. Illinois: Charles C. Thomas. $6.00.

This book of 494 pages contains considerably more than its title implies. It is not only an excellent biography of the Great German Physicist, but is also a complete history of the early experience with roentgen rays. In this portion of the book are such interesting data as the first observation on the physiological effects of roentgen rays on the human skin; the early use of roentgen ray as a therapeutic agent and the development of the roentgen tube and intensifying screens.

There is a complete bibliography of books and pamphlets on roentgen ray published during the year 1896; and when one considers that Roentgen announced his discovery in December, 1895, one is rather amazed to find that there were 49 books or pamphlets and over 1000 articles published the following year. In this list of articles are nearly all of the subjects under discussion to-day.

The book contains a vast amount of historical data related to the roentgen ray. In establishing these facts the author has exhausted every source of information and has included the references to these data in the bibliography. The book is easy to read and well printed.

As a book of reference it should be particularly valuable to those who wish to determine priority in any therapeutic or diagnostic procedure relating to the roentgen ray.

Traité de Physiologie Normale et Pathologique. Tome V. Respiration. Publié sous la direction du Pr. G. H. Roger et du Pr. Léon Binet. 474 pp. Paris: Masson et Cie. 80 fr.

Other volumes of this work have previously been reviewed in these columns. It may be recalled that the project is to publish the data of the science in great detail and to resume the collection of material as soon as each section is issued looking toward a new edition. With more than a hundred collaborators eleven large volumes have now been published and two of these are soon to be replaced by revisions. The present unit appears to maintain the high standard set in its predecessors. Naturally, a large proportion of the references are to French sources; this is really a strong point for the book since these are the papers among which we are most apt to miss valuable reports. The chapter by Heymans on the nervous control of breathing will be of unusual importance because of the author's far-reaching discoveries with respect to the carotid sinus. Mention may also be made of the interesting treatment of basal metabolism by Hermann and of respiration at high altitudes by Binet.

Studies from The Rockefeller Institute for Medical Research. Reprints. Volume 88. 621 pp. New York: The Rockefeller Institute for Medical Research, 1934.

A very wide range of subjects is presented, covering the various departments of the Institute. From the medical standpoint the papers of particular interest are those by Rhoads and Castle on the pathology of the bone marrow in sprue, on focal cell reactions in tuberculosis by Theobald Smith, and infectious papillomatosis of rabbits by R. E. Shope.

From the standpoint of the laboratory worker, the three papers by H. M. Evans dealing with prolan are of particular interest.

Birth Control in Practice. Text and Tables by Marie E. Kopp. Prepared under the supervision of a scientific advisory committee. 290 pp. New York: Robert M. McBride & Company. $3.75.

"Birth Control in Practice" is a statistical study of the first ten years' work of the Birth Control Clinical Research Bureau of New York comprising the facts obtained from an analysis of ten thousand case histories. Some idea of the scope of this study can be gained from a glance at the Table of Contents; statistics are presented concerning patients' reasons for seeking birth control advice, their nativity and national background, education, religious affiliations, occupations, weekly income, health, age and characteristics of husband, menstrual history, marital and obstetric history, including sexual habits and reactions, reasons for being given contraceptive advice, and other factors involved in the problem. The important findings are given in a brief summary of nine pages; by reading this carefully, one will get the gist of the study.

The book is a valuable contribution to our understanding of the problems of marriage and the sexual life. As Adolf Meyer, who wrote the foreword, very wisely remarks: "To bring sex-life in its positive and not only its dismal aspects into contacts with safe and sane and intelligent medical experience will be a tremendous forward step beyond the haphazard and often tragic conditions of the present day." "Birth Control in Practice" will help give us a foundation of knowledge upon which we may base the treatment of those patients whose problems are related to this important phase of life.